Supreme Court, U.S.
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In The

Supreme Court of the United States

PETER MACKBY,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

PATRIC HOOPER (SBN 57343)
HOOPER, LUNDY & BOOKMAN, INC.
1875 Century Park East,
Suite 1600
Los Angeles, CA 90067-2799

Tel: (310) 551-8165
Fax: (310) 551-8181

Attorney for Petitioner

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether the False Claims Act, 31 U.S.C. Sections 3729-3733 ("FCA"), should be interpreted as a criminal or quasi-criminal statute, and, if so, whether a plausible benign interpretation of complex Medicare rules prevents a Medicare claim from being considered "false."

2. Whether the government is "damaged" under the FCA by the submission of "false" Medicare claims for prescribed health care services when the government would have paid another party the very same sum it paid the defendant if the claims had been "true."

3. Whether damages must be proven as an element of an FCA violation, or, at least, as a basis for recovering treble damages.

4. Whether the judgment here awarding the government statutory penalties under the FCA of $555,000 may be upheld if the only way the penalties avoid being unconstitutionally excessive under the Eighth Amendment is by counting 111 claims to determine the total penalties while counting 8,499 claims to determine the reasonableness of the per claim penalty.

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PETITION FOR WRIT OF CERTIORARI

Petitioner, Peter Mackby, respectfully prays that a writ of certiorari issue to review the opinions of the United States Court of Appeals for the Ninth Circuit, filed August 16, 2001, and August 12, 2003, and the Judgment filed August 12, 2003. As indicated below, until Mr. Mackby's timely-filed Petition for Panel Rehearing was denied by the Court of Appeals on September 12, 2003 (Appendix at 73), these decisions and Judgment did not become final for purposes of triggering the time to petition for Supreme Court review.

OPINIONS BELOW

The United States District Court for the Northern District of California filed two decisions in this case and the United States Court of Appeals for the Ninth Circuit filed four. The decisions are:

1. The August 12, 2003, decision of the Ninth Circuit, reported at 339 F.3d 1013 (9th Cir. 2003) and August 12, 2003 Judgment, Appendix at 1-15.
2. The June 3, 2003, unpublished memorandum of the Ninth Circuit. Appendix at 34-36.
3. The September 3, 2002 "Order re Excessive Fines Clause," of the District Court, reported at 221 F. Supp.2d 1106 (N.D. Cal. 2002). Appendix at 37-55.
4. The August 16, 2001 Decision of the Ninth Circuit, reported at 261 F.3d 821 (9th Cir. 2001). Appendix at 16-33.
5. The March 21, 2001 Decision of the Ninth Circuit, reported at 243 F.3d 1159 (9th Cir. 2001).
6. The District Court's March 8, 1999, Findings of Fact and Conclusions of Law and March 10, 1999, Judgment. Appendix at 56-72.

JURISDICTION

The District Court originally asserted jurisdiction over this matter pursuant to 31 U.S.C. Section 3730(a), as well as under 28 U.S.C. Section 1345. Appendix at 65. After a three-day court trial, the District Court entered Judgment in favor of the United States against Mr. Mackby under the FCA in the amount of $729,454.92. Appendix at 72. The Judgment was expressly based on a $5,000 civil penalty for each of 111 Medicare claims totaling $555,000, plus treble damages of $174,454.92 based on total Medicare payments of $58,151.64. 339 F.3d at 1015. Appendix at 5.[1]

The Court of Appeals exercised jurisdiction to review the original District Court decision pursuant to 28 U.S.C. Section 1291. On appeal, the Ninth Circuit affirmed the District Court's finding that Mr. Mackby had violated the FCA but remanded the case to the District Court to determine whether the civil penalties of $555,000 and the treble damages of $174,454.92 violated the Excessive Fines Clause of the Eighth Amendment. On remand, the District Court upheld the full amount of the Judgment. A different panel of the Court of Appeals then affirmed the decision on remand on June 3, 2003, exercising jurisdiction under 28 U.S.C. Section 1291. Appendix at 34-36.

The government requested the Court to publish the June 3, 2003, memorandum decision. Appendix at 80-81. Mr. Mackby filed a Petition for Panel Rehearing and Suggestion for Rehearing En Banc on July 7, 2003. Because the Court of Appeals decided to withdraw its June 3, 2003, memorandum decision and simultaneously replace it with a published opinion, the Ninth Circuit denied Mr.

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[1] The District Court's March 8, 1999, Conclusions (Appendix at 70) and Court of Appeals' August 12, 2003, Opinion, erroneously report the total statutory penalties as $550,000, rather than $555,000. 339 F.2d at 1015. Appendix at 5.

Mackby's July 7, 2003, Petition on mootness grounds. However, Mr. Mackby then filed a new Petition for Panel Rehearing and Suggestion for Rehearing En Banc to challenge the Court of Appeals' August 12, 2003, published opinion.

On September 12, 2003, the Court of Appeals denied the new Petition. Appendix at 73. The proceedings below thus became final on September 12, 2003. As a result, the jurisdiction of this Court to review the decisions of the Court of Appeals is invoked under 28 U.S.C. Section 1254(1).

THE RELEVANT CONSTITUTIONAL PROVISIONS, STATUTES AND RULES

A. The Eighth Amendment To The United States Constitution

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

B. 31 U.S.C. Section 3729

(a) Liability for certain acts. – Any person who –

(i) knowingly presents, or causes to be presented, to an officer or employee of the United States government . . . a false . . . claim for payment or approval;

. . .

is liable to the United States government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the government sustains because of the act . . . .

C. 31 U.S.C. Section 3731(c)

In any action brought under Section 3730, the United States shall be required to prove all essential elements of

the cause of action, including damages, by a preponderance of evidence.

D. The applicable Medicare statutes and rules are reprinted in the Appendix at App. 74-79.

STATEMENT OF THE CASE

A. The Facts

1. Background

Mr. Mackby owned and operated a physical therapy clinic, Asher Clinic, in California between 1982 and 1997. Before 1988, he owned Asher Clinic with a partner, Mr. Leary, who was a licensed physical therapist. In 1988, he bought out Mr. Leary and formed a general law corporation to own and operate Asher Clinic, known as M-1 Enterprises ("M-1"). Appendix at 19. Before doing so, Mr. Mackby's then-lawyers obtained an opinion from the Physical Therapy Examining Commission of the California Board of Medical Quality Assurance confirming that a general law corporation, such as M-1, may employ licensed physical therapists to furnish physical therapy services in California. *See* June 6, 1988, letter, Record Excerpts, Appellate Court proceedings, at 250.

During the period at issue in this FCA action, 1992-1996, Mr. Mackby operated Asher Clinic through this wholly owned corporation, M-1, which employed licensed physical therapists to treat all categories of patients for physical therapy services, including Medicare patients. There has never been a dispute here about the medical necessity, quality, or health and safety of the physical therapy services rendered by Asher Clinic's physical therapists or over the Medicare payment rates applicable to the individual physical therapy services. Rather, the dispute has always centered on Asher Clinic's eligibility to receive Medicare payments in the first place and the annual limit ("cap") on physical therapy services under the

Medicare regulatory provisions set forth in the Appendix at 74-79.

Medicare originally covered and paid for qutpatient physical therapy services under Part B of the program *only* when they were provided by or under the supervision of a physician. Thus, in *Peterson v. Weinberger*, 508 F.2d 45, 52 (5th Cir. 1975), the Court upheld FCA liability when the defendant submitted Medicare claims for physical therapy services that were purported to have been rendered by or under the supervision of a doctor but actually had been rendered by a physical therapist. However, in 1972, Congress amended the Medicare statute, effective July 1, 1973 (which postdated the services in *Peterson*), to provide Medicare Part B coverage for the first time for outpatient physical therapy services furnished *by licensed physical therapists* as well as by or under the supervision of physicians. 42 U.S.C. § 1395x(p) (as amended in 1972) (Appendix at 74).

The Secretary of Health and Human Services, who administers the Medicare program, then issued regulations to implement the amended statute, which provided Medicare Part B coverage for physical therapy services furnished (1) by physicians or under the supervision of physicians and (2) by physical therapists, themselves. *See* 42 C.F.R. § 410.60 [1996] (superseded) (Appendix at 75-76). Between 1992 and 1996, the regulation provided that, unlike under California State licensing law, the physical therapists must be in "independent practice," which meant that they must furnish services without the administrative and professional control of a lay employer. *See* 42 C.F.R. § 410.60(c)(1)(ii) [1996] (superseded.). However, during this same time, the Secretary actually interpreted the regulation as permitting a corporation to employ physical therapists so long as one of the persons in the group was a physical therapist. *See* Form HCFA-262 (5-84). Supp. Record Excerpts at 325.

Also, between 1992 and 1996, the Secretary imposed limits on the annual amounts Medicare would allow

beneficiaries to incur as expenses for physical therapy services furnished by physical therapists in independent practice. *See* 42 C.F.R. § 410.60(c)(2) [1996] (superseded) (Appendix at 76). These annual limits, however, did not apply to outpatient physical therapy services furnished by a physician or under the supervision of a physician between 1992 and 1996. Appendix at 18. Thus, although the Medicare payment rates were the same whether physical therapy services were rendered or supervised by a physician or rendered by a physical therapist, (*see* Medicare Carriers' Manual, § 15002) (Appendix at 77), the annual cap on the beneficiaries' expenses for such services only applied to services furnished by physical therapists.

In 1998, the Secretary, consistent with California licensing law, amended the Medicare regulation to "redefine" those physical therapists who could provide Medicare-covered physical therapy services to include physical therapists who are employed by lay corporations. 42 C.F.R. § 410.60(c)(1) [1999]. Moreover, the annual limits on expenses were also expanded in 1998 to apply to physical therapy services furnished by or under the supervision of a physician. *See* 63 Fed. Reg. 58867-58868 [Nov. 2, 1998], and 42 C.F.R. § 410.60(e) [1999].[2]

2. Asher Clinic's Billing Procedures

In 1988, Mr. Mackby formed M-1 to operate Asher Clinic. In November 1989, his lawyer gave Mr. Mackby a copy of the Medicare instructions, referred to above at page 5, which allowed physical therapists to practice in a corporation as a group. Supp. Record Excerpts at 324-325.

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[2] Congress ordered the Medicare administration to suspend application of the annual physical therapy cap during the last several years and to study its efficacy. *See* 42 U.S.C. § 1395l(g)(4), as amended by P.L. 106-554, § 421, U.S.C.C.A.N. (Feb. 2001).

Mr. Mackby interpreted these instructions as allowing him to satisfy the Medicare requirements by making his father, Judson Mackby, a doctor, an officer of M-1, which he did in October 1989. Reporter's Tr. at 586; Supp. Record Excerpts, 229.

In the meantime, to make a "seamless transition" after he bought out his partner (Appendix at 63), Mr. Mackby instructed Asher Clinic's outside billing company in 1988 to substitute his physician father's medical license number for his former partner's physical therapy license number to identify Asher Clinic's physical therapy services. While Mr. Mackby's father is a physician and served as an officer of M-1 between 1989 and 1996, he did not then live in California and thus did not furnish or supervise the furnishing of physical therapy services at Asher Clinic. Appendix at 60.

Rather, as had been the situation when Mr. Leary was Mr. Mackby's partner, only licensed physical therapists rendered the services to Medicare patients at Asher Clinic pursuant to the orders of the patients' attending physicians. Record Excerpts, 220-221, 250-251. And, as explained below, the physical therapists' names often appeared on the Medicare bills in the box identifying the person who furnished or supervised the services. The Medicare rates paid to Asher Clinic were the same as the rates that would have been paid if the services had been rendered by or under the supervision of a physician. Medicare Carriers Manual, Section 15002.

Because Dr. Mackby's Medicare license number (but not name) was placed in two boxes (Box 24k and Box 33) of the Medicare claims form, HCFA Form 1500, to identify Asher Clinic's physical therapy services, the Medicare carrier, Blue Shield, paid Asher Clinic as if its physical therapy services had actually been furnished by or under the supervision of a physician rather than by physical therapists. The Medicare carrier did so even though in Box 31 of the very same Medicare claims, Asher Clinic often

listed the name of the physical therapist who actually rendered or supervised the rendering of the services. *See*, Sample Claim, HCFA Form 1500, Appendix at 82. The actual Medicare checks were made out by the carrier to Dr. Mackby but were sent to Asher Clinic. Dr. Mackby was a cosigner on Asher Clinic's bank account and the checks were thus deposited through the use of a rubber stamp containing Dr. Mackby's and Asher Clinic's names. Trial Exhibit Nos. 16 and 60.

The Medicare carrier made no attempt to inquire about any ambiguities on the claims form nor did the carrier take any steps to inquire into the situation further after being expressly informed by Asher Clinic on June 28, 1991 (Appendix at 90) (which predated the period at issue) that Asher Clinic wanted to substitute the license number of one of its physical therapists for Dr. Mackby's license number. Rather, the Medicare carrier simply replied (Appendix at 91) that it was "unable to comply with" Asher Clinic's request because "Medical doctors cannot be added to physical therapy groups," an obvious acknowledgment by the Medicare carrier of the actual character of Asher Clinic.

Between 1992 and 1996, Asher Clinic's physical therapists furnished physical therapy services to Medicare patients and submitted a total of 8,499 Medicare claims for which Medicare paid it $331,078, or an average of approximately $40 per Medicare claim. Of these 8,499 claims, 1,459 were for services that exceeded the then-annual physical therapy cap, for which Medicare paid a total of $58,151.64. 339 F.2d at 1015. Appendix at 4-5.

B. The Proceedings Below

The government filed an FCA action against Mr. Mackby in the District Court in 1998 originally seeking treble damages for all Medicare sums paid Asher Clinic (3 x $331,078) and statutory penalties for all Medicare claims

submitted by Asher Clinic, ($5,000 to $10,000 for each of the 8,499 claims). However, prior to trial, the government substantially limited its action, seeking treble damages only for the Medicare payments exceeding the cap, $58,451.64, and statutory penalties of $5,000 per claim for 111 claims ($555,000), which represented one claim for each of the beneficiaries for whom Asher Clinic had received payments in excess of the physical therapy cap. Appendix at 4-5.

After a three-day court trial during which the government presented absolutely no evidence of any actual damages or loss, the Court granted the relief requested by the government. The Court concluded that Mr. Mackby had acted recklessly in submitting claims using his father's number, which claims were false. The Court also held that the government did not have to prove actual damages to recover FCA "penalties." Appendix at 70.

On appeal, the Ninth Circuit affirmed the District Court's "finding" that the claims submitted by Asher Clinic were thereby false because the finding was "not clearly erroneous," 243 F.3d at 1164. The Court also rejected Mr. Mackby's reliance on criminal FCA cases to support the argument that the claims should not be actionable under the FCA if the claims were supported by a plausible interpretation of the governing Medicare principles. 243 F.3d at 1164. The Court, however, questioned the amount of the treble damages and the civil penalties and therefore remanded the case to the District Court for a determination of whether the treble damages and statutory penalties violated the Excessive Fines Clause of the Eighth Amendment. 243 F.3d at 1166-1168.

The government subsequently asked the Court to rehear the case arguing that by definition FCA treble damages could never be grossly disproportional to the gravity of a defendant's offense. The Court granted the government's Petition for Rehearing, withdrew its original decision, and then substituted a new published decision,

which similarly remanded the case to the District Court to apply an Excessive Fines Clause analysis to the civil penalty *and* treble damages portions of the Judgment. 261 F.3d at 829-831. Appendix at 28-33. The Court added that it expressed no opinion as to whether such an analysis would be appropriate in a case where only treble damages were awarded, or "where the civil penalty was not of such a substantial magnitude as it presently is in this case." 261 F.3d at 831. Appendix at 32.

On remand, the District Court upheld the full amount of its previous judgment concluding that the total sum awarded was not grossly disproportional to the gravity of the offense. In doing so, the Court considered for the first time all 8,499 Medicare claims submitted by Asher Clinic and all the moneys paid by Medicare to Asher Clinic, $331,078 for services provided between 1992 and 1996, even though the District Court had originally granted an award of treble damages and statutory penalties based only on Medicare payments totaling $58,151.64 for 111 claims.

Thus, on remand, the District Court compared the maximum treble damages, which purportedly could have been awarded, nearly $1,000,000, with the treble damages that were actually awarded, $174,454.92, and the maximum amount of the statutory penalties, which purportedly could have been imposed, nearly $85 million, with the statutory penalties that were actually imposed, $555,000, to insinuate that Mr. Mackby was fortunate to have had a judgment imposed of only $729,454.92. Given the maximum judgment that purportedly could have been imposed, approximately $86,000,000, the actual judgment of approximately $730,000 was necessarily reasonable, according to the District Court. Appendix at 44.

In its August 12, 2003 decision, the Court of Appeals applied similar reasoning. For example, it pointed out that if the government had sought damages for all 8,499

claims, Mr. Mackby would have faced a maximum civil penalty of $84,990,000 ($10,000 per false claim) and the maximum treble damages award could have been $993,234. Thus, according to the Court of Appeals, the substantial difference between the actual judgment imposed on Mr. Mackby and the maximum that was purportedly available "weighs against a finding of gross disproportionality." 339 F.3d at 1018. Appendix at 10.

In addition to the above, it must be emphasized that the District Court found for the first time on remand, and the Court of Appeals affirmed in its August 12, 2003 opinion, that none of the physical therapy services furnished at Asher Clinic to Medicare patients between 1992 and 1996 were covered by Medicare. According to the District Court, if Asher Clinic's claims had not been presented with Dr. Mackby's number, the Medicare carrier would have determined that the services were not covered by Medicare because they had not been furnished by or under the supervision of a physician or a qualified physical therapist in independent practice under the rules that were in effect between 1992 and 1996. Appendix at 45.

As a result, according to this reasoning, to have had their prescriptions for physical therapy services covered by Medicare, the patients would likely have gone to a physician or supplier who was eligible to have provided Medicare-covered physical therapy services without the cap. Indeed, in its August 16, 2001 Opinion, the Court of Appeals expressly recognized this obvious reality:

> **If Asher Clinic had been held to the billing cap and had tried to bill its patients directly for amounts in excess of the cap, the patients could have, and it seems reasonable that they very well would have, left to seek services from physicians or physician-run clinics where the cap did not apply, so that they could receive Medicare benefits covering the full amount of physical therapy services, rather than pay Asher Clinic**

> **out of their own pockets the amounts billed in excess of the cap.**

261 F.3d at 829, Appendix at 27.

This same reasoning applies to all of Asher Clinic's physical therapy services. In other words, because the physical therapy services furnished to the Medicare patients had been ordered by their physicians, the patients would have sought treatment from someone who could have furnished Medicare-covered services rather than paying for them out of their own pockets, and Medicare thus would have paid the same amount for the same services. Thus, this is *not* a case involving nonrendered, inadequate or unnecessary services.

REASONS WHY THE PETITION SHOULD BE GRANTED

A. The Petition Raises Important Questions of Federal and Constitutional Law That Have Not Been, But Should Be, Settled By This Court

The government has repeatedly acknowledged the importance of this case with respect to the ongoing application of the FCA. For example, in its June 6, 2003 letter to the Court of Appeals (Appendix at 80-81), requesting publication of the June 3, 2003 memorandum disposition, the government emphasized that the Court's August 16, 2001 opinion (261 F.3d 821) was the first appellate opinion holding that the Excessive Fines Clause of the Eighth Amendment applies to FCA judgments. According to the government, as of June 2003, there had been no published appellate opinion actually *applying* the Excessive Fines Clause analysis to an FCA case. Thus, the government

pointed out that "litigants lack insight into how appellate courts apply the Clause in FCA cases."[3]

Because the FCA is the government's primary litigative tool for "recouping losses suffered through fraud," *see Vermont Agency of Nat. Resources v. U.S.*, 529 U.S. 765 (2000), the resolution of the questions presented is critical to the uniform application of the FCA to all types of government contractors. However, the questions are especially important to the health care industry where health care fraud cases currently surpass all other types in which the FCA is used. *See* John T. Boese, *Civil False Claims and Qui Tam Actions*, Sections 1.01 and 1.05 [A] (2d. Ed. & Supp. 2003), Aspen Publishers, and Robert Salcido, *Health Care Fraud and Abuse: Practical Perspectives*, American Bar Association, Health Law Section, Ch. 3.I, pp. 113-116 (Linda A. Baumann, Editor, 2002).

The correct resolution of the questions raised by this Petition will help protect members of the health care industry from the government's continuing attempts to use the FCA to try to obtain exorbitant money settlements in connection with complex Medicare and Medicaid regulatory disputes, which often should be resolved through existing regulatory processes rather than through the use of the FCA.[4] *See, for example, Ohio Hosp. Ass'n v. Shalala*, 201 F.3d 418, 419, 424-425 (6th Cir. 1999), where the

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[3] The decisions in this case have also generated considerable interest among courts and legal commentators as evidenced by the fact that they have already been cited by many courts and commentators.

[4] Indeed, the Courts have repeatedly recognized that the FCA may not be used to remedy all violations of regulatory laws and rules. *See Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 733 (7th Cir. 1999); *United States ex rel. Lamers v. Green Bay*, 168 F.3d 1013, 1019 (7th Cir. 1999) and *U.S. ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266-67 (9th Cir. 1996).

Court of Appeals noted the district court's concern about the "heavy handed" nature of the government's FCA tactics.

This Court has also recognized the need for providing continuing guidance on FCA issues, especially those issues regarding FCA damages and statutory penalties. For example, in last year's term, the Court discussed the nature of the treble damages and the civil penalties in *Cook County, Ill. v. U.S. ex rel. Chandler*, ___ U.S. ___, 123 S.Ct. 1239 (2003). The Court had previously discussed similar issues in *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, *supra*.

One of the questions presented for review here, the necessity of damages for FCA liability, was one of the three questions for which certiorari was granted by this Court in *Hughes Aircraft Co. v. United States ex rel. Schumer*, 519 U.S. 926 (1996). However, the Court did not resolve the issue because it decided that case on different grounds. The related question of how damages should be determined under the FCA has also been scrutinized by this Court. For example, in *United States v. Bornstein*, 423 U.S. 303 (1976), the Court discussed damages issues of the type raised here.

The questions here also involve important issues that have recently been addressed by this Court in the somewhat analogous situation of excessive punitive damages awards in state court tort actions. For example, in *State Farm Mut. Auto Ins. Co. v. Campbell*, ___ U.S. ___, 123 S.Ct. 1513 (2003), the Court voiced its concern about civil proceedings imposing awards serving the same purposes as criminal penalties without affording defendants the protections of criminal proceedings. 123 S.Ct. at 1520. The Court also commented upon the potential denial of due process caused by punitive damages awards that are imposed without any objective standards. *Id.* Both concerns are present here.

B. The Court of Appeals' August 16, 2001 Opinion Conflicts at Least In Principle With The Decisions of This Court and Others Regarding Whether the FCA Should Be Interpreted as a Criminal Statute

Based on the testimony of an employee of the Medicare carrier and an "independent" physical therapist witness, the District Court concluded that Asher Clinic's Medicare claims for amounts in excess of the physical therapy cap were "false." Appendix at 58-59. Treating this conclusion as a finding of fact, the Court of Appeal upheld it because it was "not clearly erroneous." 261 F.3d at 827, Appendix at 24. In rejecting the argument that the Medicare claims were not false under a plausible interpretation of the Medicare rules, the Court concluded that the "plausible interpretation" argument applied only in *criminal* FCA cases. 261 F.3d at 827, Appendix at 23-24. In reaching this conclusion, the Ninth Circuit departed from the holdings of this Court and others.[5]

Specifically, the Ninth Circuit's holding conflicts with the holding of the Eighth Circuit in *Hays v. Hoffman*, 325 F.3d 982, 992 (8th Cir. 2003), where in a *civil* FCA case, the Court quoted from this Court's holding in *United States v. Bornstein*, 423 U.S. at 313, n.8, that "we are actually construing the provisions of a criminal statute." Such construction is especially compelling in light of the Court's recognition that both the civil penalties and the treble damages are punitive in nature. As a result, to prove the falseness of a claim under the FCA, the government should not be able to rely on ambiguous regulatory provisions.

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[5] The Court also erred in construing the falsity issue in this case as a question of fact since it turns on the interpretation of various Medicare rules. *See U.S. ex rel. Oliver v. Parsons Co.*, 195 F.3d 457 (9th Cir. 1999).

This principle is particularly important since the government and relators often use the FCA to try to punish wrongdoers for noncompliance with complex regulatory requirements. *Compare United States ex rel. Lamers v. Green Bay*, 168 F.3d at 1020 [the "FCA should not be hauled out to punish" the city for its decision]. And, the more complex the regulatory requirements, the less applicable should be the FCA. This is critical in Medicare and Medicaid cases where the Ninth Circuit has noted that "crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes," which it characterizes as "baffling." *Beverly Community Hosp. Ass'n v. Belshe*, 132 F.3d 1259, 1266 (9th Cir. 1997). *See also Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994), where the Court described the provisions of the Medicare payment process as "among the most completely impenetrable texts within human experience."

Ironically, in most ordinary Medicare payment disputes, the government relies on the complexities and ambiguities of the Medicare and Medicaid statutes and rules to insist that the Courts uphold its interpretations of these rules. *See, for example, Thomas Jefferson University v. Shalala*, 512 U.S. 504, 512-514 (1994). However, when it functions as a "prosecutor" in FCA cases, the government characterizes the statutes and rules as simple, straightforward and unambiguous. In reality, nothing could be further from the truth. Differences over the various interpretations of the thousands of Medicare and Medicaid rules are common enough to require elaborate administrative appeal processes to resolve.[6]

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[6] According to the Mayo Clinic, the Medicare regulations, themselves, occupy more than 100,000 pages. *Mayo Chronicles Medicare Regs.: It's 132,720 Pages of Red Tape, Modern Health Care*, March 15, 1999 (Crain Publishing), at page 64. This tally does not even include the thousands of Medicare "guidelines" and "instructions."

In criminal cases, where the truth or falsity of a statement or claim turns on interpretation of regulatory provisions, the courts insist that the government prove the defendant's representation or claim is not true under "a reasonable interpretation of the law." *See U.S. v. Whiteside*, 285 F.3d 1345, 1351-1352 (11th Cir. 2002), *citing United States v. Migliaccio*, 34 F.3d 1517, 1525 (10th Cir. 1994) (holding that the government bears the burden to negate any reasonable interpretations that would make the defendant's statement correct); *United States v. Johnson*, 937 F.2d 392, 399 (8th Cir. 1991) (holding that one cannot be guilty of a false statement beyond a reasonable doubt when his statement is a reasonable construction); *United States v. Race*, 632 F.2d 1114, 1120 (4th Cir. 1980) (same); *see also United States v. Calhoun*, 97 F.3d 518, 526 (11th Cir. 1996) (government failed to prove claim false by virtue of nonreimbursable nature of the interest). In *Whiteside*, the Court reversed the conviction of a defendant because of differing interpretations of certain Medicare regulatory requirements. The Court concluded a statement based on such complex requirements could not be false as a matter of law. 285 F.3d at 1353.[7]

Here, it is plausible and, in fact, reasonable to interpret the requirements at issue as permitting payment to Asher Clinic for its physical therapy services. For example, there is no *substantial* issue about Asher Clinic's Medicare eligibility. As a "supplier" (rather than a provider) consisting of a group of independent physical therapists, it did not have to have a "provider" agreement with Medicare. *See* 42 C.F.R. § 489.2 [1996] and § 489.3 [1996] [limiting Medicare agreements only to providers]. Indeed, the only possible reason Asher Clinic's physical therapists would

[7] Ironically, the Ninth Circuit has applied the defense of "plausible" interpretation even in *civil* FCA cases. *See U.S. ex rel. Hochman v. Nackman*, 145 F.3d 1069, 1075 (9th Cir. 1998).

not have fully qualified as being in "independent practice" under then-existing 42 C.F.R. § 410.60 is because they were employed by a lay corporation, which was permitted under California licensing law. However, the Medicare instructions actually allowed a group of physical therapists to function in the setting of a corporate entity. In any event, such a "technical violation" of a Medicare regulation does not cause Medicare claims to be false under the FCA. *See, e.g., U.S. ex rel. Lamers v. City of Green Bay*, 168 F.3d at 1019 [minor technical violations do not give rise to an FCA claim].

In any event, the Medicare claims, themselves, do not contain any express representation relating to the arcane requirements of "independent practice." *See* sample claim, Appendix at 82. Thus, Mr. Mackby could not have been deemed to have certified compliance with the independent practice requirement, and, therefore, any purported noncompliance with it could not have given rise to FCA liability. *See U.S. ex rel. Mikes v. Straus*, 274 F.3d 683, 697 (2nd Cir. 2001) [a claim under the FCA is legally false *only* when a party certifies compliance with a statute or regulation as a condition of payment.]

In fact, the only express certifications in the Medicare HCFA-1500 claims submitted by Asher Clinic, like those in *Mikes*, 274 F.3d at 698, were that the services were medically necessary and furnished personally or under the immediate supervision of the person listed in *Box 31* of the form, which is the actual box on Asher Clinic's claims in which physical therapists' names regularly appeared. *See* sample claim, Appendix at 82, stating:

31. Signature of physician or supplier including degrees or credentials (I certify that the statement on the reverse apply to this bill and are made a part thereof).
Pickell Steve RPT
062096
Signed Date

Dr. Mackby's *name* appeared nowhere on Asher Clinic's claims. His license number appeared only in Box 24 – marked "reserved for local use" and in Box 33 marked "physician supplier's billing name, address, zip code and phone #." Neither situation expressly purported to identify the person who rendered or supervised the services.

It is only because the Medicare carrier mistakenly interpreted these two boxes as containing the identity of the person who actually provided or supervised the provision of the physical therapy services that the carrier treated Asher Clinic as a physician-run clinic. Such an interpretation, even if reasonable, however, does not negate the express requirement of the certification in Box 31, the only express certification on the claims, which describes Asher Clinic physical therapists as the persons who rendered or supervised the rendering of the services.

Thus, Mr. Mackby could plausibly interpret his father's presence as a corporate officer of M-1 and the description of the physical therapist on the claim form as satisfying the applicable Medicare requirements. At worst, Dr. Mackby's number in Boxes 24 and 33 rendered the claims ambiguous, but not false.[8]

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[8] Throughout these proceedings, the government demonized Mr. Mackby for using his father's number without his father's knowledge, according to his father, with whom he had been feuding in recent years. Such action, which Mr. Mackby steadfastly denies to this day, should not be the subject of an FCA action. *See US. ex rel. Mikes v. Straus*, 274 F.3d at 697 (the FCA is not designed to reach every kind of purported fraud practiced on the government.)

C. The Court of Appeals' August 12, 2003 Opinion Conflicts at Least in Principle With the Decisions of this Court and Others on the Damages Issue

A leading commentator on the subject has pointed out that while determining actual damages under the FCA might appear to be simple and straightforward, the published decisions "reveal much inconsistency and confusion on the part of judges, juries, and attorneys attempting to measure the government's damages" under the FCA. John T. Boese, *Civil False Claims in Qui Tam Actions*, Ch. 3, § 3.01, pp. 3-5 (2d. Ed. & Supp. 2003). *See also* pages 3-24 and 3-25, where, after discussing the general rule that the measure of the government's damages is the amount it paid out by reason of the false statements over and above what it would have paid if the claims had been truthful, Mr. Boese points out that different Courts of Appeals have reached different conclusions regarding defendants' liability for damages. For example, in "false certification" cases the courts of appeals appear to be split regarding whether a broad or narrow test of causation is appropriate under the FCA. *Id.*

Here, the Court of Appeals applied an overly broad test, which ignored the critical fact that the government did not present any evidence of actual damages or loss at trial, and was not, in fact, actually damaged by Asher Clinic's "false" claims because Medicare would have paid the same for the physical therapy services that were provided by Asher Clinic even if Asher Clinic had submitted "truthful" claims. Indeed, if the claims had been "true," the patients would have gone elsewhere to receive their prescribed physical therapy services since otherwise Medicare would not have covered them at Asher Clinic. Medicare would then have paid someone else the same amounts it paid Asher Clinic for the same physical therapy services.

The critical point is that Asher Clinic's Medicare patients actually received the physician-ordered physical therapy services from licensed physical therapists at Asher Clinic. And, as pointed out above, after 1973, services furnished by physical therapists were covered by Medicare. This important fact distinguishes this case from *Peterson v. Weinberger*, *supra*, where, at the time the services in that case were rendered, *only* doctors could furnish or supervise the furnishing of physical therapy services. Because the services had been furnished by licensed physical therapists rather than doctors in *Peterson*, they were neither covered nor payable by Medicare. Thus, unlike here, if the claims had truly reflected who rendered them, Medicare would *not* have paid for them in *Peterson*.

Here, however, Medicare Part B would have ultimately paid for the services if the Medicare carrier had interpreted them as being rendered by the physical therapists who actually rendered them. And, the Medicare carrier would have paid the same rates for the same services. Moreover, if the claims had been interpreted by the carrier as being services furnished by physical therapists, rather than a doctor, the annual cap would have been applied, which, as pointed out by the Ninth Circuit, would likely have caused the patients to go elsewhere to receive their services, causing Medicare to have paid the same amounts it paid Asher Clinic.

The District Court and the Court of Appeals ignored this obvious fact and instead simply characterized the Medicare amounts actually paid to Asher Clinic as the government's damages. Decisions in other Courts of Appeals, including the Eighth Circuit and the Federal Circuit, conflict with this approach. For example, in *United States v. Cooperative Grain and Supply Co.*, 476 F.2d 47, 63-64 (8th Cir. 1973), the Court held that the government should only be allowed to recover damages that it has actually suffered as a result of a claim being submitted, plus statutory penalties.

Similarly, in *Ab-Tech Constr. Inc. v. United States*, 31 Fed.Cl. 429 (1994), *aff'd.*, 57 F.3d 1084 (Fed. Cir. 1995), the government claimed damages of three times the amount the defendant was awarded on the basis of false progress payments. The Court rejected the damages claim holding that damages must represent compensation for a loss or injury actually sustained by the government. And, because the government submitted no proof of any actual loss or damages, the Court indicated it had no basis for granting the government's demand for treble damages.

As indicated above, at trial here, the government presented absolutely no evidence of any actual loss or damages. Rather, it simply assumed that it was damaged in a sum equal to the amount Medicare paid for the false claims without refuting Mr. Mackby's contention that Medicare would have paid someone else the same for the same medically necessary services if the patients could not have received covered Medicare services at Asher Clinic.

The District Court and the Court of Appeals characterized Mr. Mackby as arguing "no harm, no foul," which, according to the Court of Appeals, Congress specifically rejected in amending the FCA in 1986. Indeed, to support its position, the Court quotes from the FCA legislative history where Congress indicated that a false claim for Medicare or Medicaid reimbursement should be "actionable" under the FCA even though the services are provided as claimed if, for example, the claimant is ineligible to participate in the program. 339 F.2d at 1019. Appendix at 11-12. Rather than supporting the Court of Appeals' conclusion regarding *damages*, the quoted material from the FCA legislative history simply suggests that the "no harm, no foul" assertion does not defeat a *cause of action* under the FCA. In such a situation, liability might exist. However, *damages* would not be warranted unless the government meets its burden of proving actual damages or loss under 31 U.S.C. Section 3731(c). If the government fails to meet its burden, statutory penalties are intended

to cover any intangible or other unquantified harm the government might have suffered.

The Court of Appeals' decision here on damages is also inconsistent with a series of criminal cases involving the submission of false statements or claims. As pointed out above, the courts have treated the provisions of the FCA as if they are provisions of a criminal statute. *Hays v. Hoffman*, 325 F.3d at 982, 992. In one such criminal case, *United States v. Renick*, 273 F.3d 1009, 1026 (11th Cir. 2001), the Court upheld a trial court's conclusion that the government had failed to present sufficient evidence to support its loss calculation involving false billings to a government health care program. The Court noted that there was no support for the proposition that the total payment amount for false medical bills should be considered the "loss" to the government, which is the measure used by the district court and the Court of Appeals in the instant case. *See* 273 F.3d at 1026-1027.

In reaching its decision, the Court in *Renick* relied on cases from other circuits, including the Ninth Circuit, citing *United States v. Rutgard*, 116 F.3d 1270, 1294 (9th Cir. 1997) [finding error for district court to base Medicare fraud loss on total proceeds of medical practice because the practice was allegedly "permeated with fraud," and requiring the court to offset the value of the services furnished by Dr. Rutgard] and *United States v. Barnes*, 125 F.3d 1287, 1290-91 (9th Cir. 1997) [holding that there was no monetary loss to anyone and that credit must be given for the amount of satisfactory services performed by a defendant impersonating a doctor.]

Also, in *U.S. v. Liss*, 265 F.3d 1220, 1231-32 (11th Cir. 2001), which was not discussed in *Renick*, the Court held that where the medical necessity of services is unquestioned, there is no basis for assuming loss in the absence of any proof of any actual loss or damages. These decisions conflict with the reasoning of the Ninth Circuit here.

D. The Court of Appeals' August 12, 2003 Opinion Conflicts with the Decisions of Other Courts Regarding the Legal Impact of the Government's Failure to Prove Actual Damages

As discussed above, the government failed to prove or even offer evidence of any actual damages or loss resulting from the submission of the "false" claims in this case. As a result, at the very least, the award of treble damages must be set aside. Moreover, contrary to the reasoning of the District Court and the Court of Appeals, the failure of the government to prove actual damages should void Mr. Mackby's liability in this case.

The Courts are divided as to the need for proving damages as an element of an FCA violation. *See Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 785, n.7 (4th Cir. 1999). The majority have held that it is not necessary to prove damages. However, others have held that some damage, or at least potential effect on the federal treasury, is a required element under the FCA. Indeed, this is why Congress specifies in 31 U.S.C. Section 3731(c) that damages must be proven as an "essential element" of liability under the FCA. This plain language of the statute suggests Congress' intent that damages be considered an element of a cause of action under the FCA.

The Ninth Circuit is among the majority that have rejected the notion that damages are necessary for liability to be established under the FCA. This is why the District Court and the Ninth Circuit both pointed out that actual damages are not required for the imposition of a civil penalty under the FCA. *See, e.g.*, 221 F.Supp.2d at 1110, note 5, Appendix at 43. *See also Bly-Magee v. California*, 236 F.3d 1014 (9th Cir. 2001) [rejecting district court's conclusion that relator failed to state a claim because any

recovered funds would not have been retained by the federal government, but would have been reallocated to another state.][9]

Those courts holding that some damage or at least some potential effect on the treasury is a required element of an FCA cause of action include *United States ex rel. Mikes v. Straus*, 274 F.3d at 687, 696 [language of FCA "plainly links the wrongful activity to the government's decision to pay" and "supports the conclusion that the statute reaches only those claims with the potential wrongfully to cause the government to disburse money."]; *United States ex rel. Hutchins v. Wilentz, Goldman & Spitzer*, 253 F.3d 176, 184 (3rd Cir. 2001) (as amended, August 16, 2001) ["the submission of false claims to the United States government for approval which do not or would not cause financial loss to the government are not within the purview of the False Claims Act."]; *United States ex rel. Stevens v. Vermont Agency of Natural Res.*, 162 F.3d 195, 202 (2nd Cir. 1998), *reversed on other grounds*, 529 U.S. 765 (2000) ["if there has been no injury to the United States, the qui tam plaintiff cannot recover"]; *United States v. Hibbs*, 568 F.2d 347 (3rd Cir. 1977); and *United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 200 F. Supp.2d 673, 680 (S.D. Tex. 2002) [citing lack of injury to the United States as one reason for dismissing relator's claim.]

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[9] In addition to the Ninth Circuit cases referred to above, other cases rejecting damages as an element of a cause of action include *Varljen v. Cleveland Gear Co., Inc.*, 250 F.3d 426, 431 (6th Cir. 2001); *United States ex rel. Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 785, note 7 (4th Cir. 1999); *Commercial Contractors, Inc. v. United States*, 154 F.3d 1357, 1371 (Fed. Cir. 1998); *United States ex rel. Aakhus v. Dyncorp., Inc.*, 136 F.3d 676, 681 (10th Cir. 1998); *Rabushka ex rel. United States v. Crane Co.*, 122 F.3d 559, 563 (8th Cir. 1997); *United States v. Rivera*, 55 F.3d 703, 709 (1st Cir. 1995), and *United States ex rel. Wilson v. Graham County Soil & Water Conservation Water Dist.*, 224 F.Supp.2d 1042, 1049 (W.D.N.C. 2002).

Significantly, as pointed out above, the issue of whether damages are necessary to establish liability under the FCA was one of the issues this Court granted certiorari to examine in *Hughes Aircraft Co. v. United States ex rel. Schumer*, *supra*. Most respectfully, the instant case now presents another opportunity for the Court to resolve the conflict among the courts regarding this issue.

E. The Statutory Penalties Imposed Here are Either Unconstitutionally Excessive or Violate the Plain Language of the FCA, Thus Presenting Important Questions for This Court to Resolve

At trial, the government expressly limited the claims which it was pursuing to the 1,459 Medicare claims submitted by Asher Clinic in excess of the physical therapy annual limit. And, in urging the district court to impose statutory penalties totaling $555,000, the government limited its case to 111 of those 1,459 claims for which a penalty of $5,000 per claim was requested to be assessed. Appendix at 5. The District Court then calculated treble damages of $174,454.92 based on the Medicare payment for the 1,459 claims, and statutory penalties of $555,000 based on the 111 claims.

However, as indicated above, on remand, after the Ninth Circuit characterized the civil penalties in this case as being of "such a substantial magnitude," 261 F.3d at 831, Appendix at 32, the District Court expanded its analysis beyond the scope of the trial by comparing the penalties actually imposed, $555,000, to the total penalties that could have been imposed, nearly $85,000,000, if every one of the 8,499 claims submitted by Asher Clinic between 1992 and 1996 had been counted. The District Court then held that the $555,000 actually awarded as penalties is reasonable in light of the nearly $85,000,000 sum which could have been awarded.

The District Court expanded its position on remand to avoid the obvious conclusion that the statutory penalties are, in fact, unconstitutionally excessive in this case. As indicated above, Medicare paid Asher Clinic an average of only approximately $40 for each Medicare claim. Imposing penalties of $5,000 for a claim paid at less than $40 is inherently excessive because the resulting fine is more than 125 times the amount of the government payment. No court has upheld such an extraordinary multiplier. Indeed, this Court, in *State Farm Mut. Auto Ins. Co. v Campbell*, 123 S.Ct. at 524, suggested that an award of more than four times compensatory damages in a state court tort action might be "close to the line of constitutional propriety."

Rather than confront this issue of excessiveness directly, the Court of Appeals, following the remand, also used all 8,499 claims to try to justify the purported reasonableness of the total penalties imposed by the District Court. For example, in concluding that the $555,000 total penalty is reasonable, the Court of Appeals pointed out that if the maximum statutory penalty had been applied to each of the 8,499 claims, the fine would have been $84,990,000. 339 F.2d at 1018. Appendix at 10.

If, however, each of the 8,499 false claims is actually counted as a false claim, it is obvious that the resulting per-claim calculation would violate the mandatory minimum penalty provisions of the False Claims Act. Specifically, if the total amount of the statutory penalties actually imposed in this case, $555,000, is divided by the total number of false claims, 8,499, the average penalty actually imposed per claim is only approximately $65.30. Congress requires that the minimum penalty per statutory claim be $5,000. Obviously, a penalty of $65.30 per claim violates the clear language of the FCA.

Congress cannot be deemed to have delegated to the government or the courts the authority to impose penalties of less than $5,000 per claim under the FCA. Such a

delegation would be invalid, as this Court suggested in *Whitman v. American Trucking Association*, 531 U.S. 457, 472 (2001), where it held that an agency could not cure an unconstitutionally standardless delegation of power by declining to exercise some of that power. Yet, this is precisely what the government did here in order to avoid the unconstitutionally excessive fine that would have resulted if the government and the courts abided by the express provisions of the FCA. The lower courts not only permitted the manipulation of the number of false claims by the government but employed the same technique (after remand) to judge the reasonableness of the penalties.

The fact is that, as written, the FCA will always produce an unconstitutional result in a case, such as Mr. Mackby's, involving hundreds or thousands of relatively small claims, because the penalties required by the statute are always disproportional to any possible harm or loss the government could suffer. In fact, this is why the Eighth Circuit recently rejected the calculation of the number of false claims used by the District Court in *Hays v. Hoffman*, *supra*. Otherwise, as the Court pointed out, the total penalties would have presented significant Excessive Fines Clause issues. 325 F.3d at 993.[10]

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[10] The penalty provisions of the FCA are also of doubtful constitutionality if they are interpreted to permit penalties ranging anywhere from $555,000 to $85,000,000, as construed by the Court of Appeals, because such an interpretation would implicitly delegate too much authority to the Executive Branch of the government to determine punishment for false claims and would not place a defendant on sufficient notice of the potential penalties. *See*, *generally*, *Loving v. U.S.*, 517 U.S. 748, 768 (1996) [delegation of congressional authority is valid only if Congress fixes the punishment for the offense]. *See*, *also*, *United States v. Hektoen Inst. for Medical Research*, 118 F.Supp.2d 902, 903 (N.D. Ind. 2000), *reversed on other grounds*, 277 F.3d 969 (7th Cir. 2002), *aff'd*, *sub. nom.*, *Cook Co., Ill. v. U.S. ex rel. Chandler*, *supra*.

The problem caused by the application of the statutorily mandated minimum penalty to false claims, no matter how small, is illustrated by the following chart:

Total Charges	Charge per Claim	Number of Claims	Penalty of $5000 to $10,000 Per Claim	
$100,000	$ 1	100,000	$500,000,000	$1,000,000,000
$100,000	$ 5	20,000	$100,000,000	$ 200,000,000
$100,000	$ 10	10,000	$ 50,000,000	$ 100,000,000
$100,000	$ 25	4,000	$ 20,000,000	$ 40,000,000
$100,000	$ 40	2,500	$ 12,500,000	$ 25,000,000
$100,000	$ 50	2,000	$ 10,000,000	$ 20,000,000
$100,000	$ 100	1,000	$ 5,000,000	$ 10,000,000
$100,000	$ 250	400	$ 2,000,000	$ 4,000,000
$100,000	$ 500	200	$ 1,000,000	$ 2,000,000
$100,000	$ 1,000	100	$ 500,000	$ 1,000,000
$100,000	$ 2,500	40	$ 200,000	$ 400,000
$100,000	$ 5,000	20	$ 100,000	$ 200,000
$100,000	$ 10,000	10	$ 50,000	$ 100,000
$100,000	$ 25,000	4	$ 20,000	$ 40,000
$100,000	$ 50,000	2	$ 10,000	$ 20,000
$100,000	$100,000	1	$ 5,000	$ 10,000

Thus, where low dollar amount claims are involved, such as $10 per claim, the same total sum falsely claimed, $100,000, will result in minimum mandatory penalties of $50,000,000, while one large claim for that same $100,000, will result in a maximum penalty of only $10,000. Although the actual sum paid by the government would be the same in both cases, *i.e.*, $100,000, the total mandated statutory penalties would differ by $49,990,000. Any statute that allows such a wide range of penalties for the same amount of actual loss or damages is unconstitutional on its face, or, as here, as applied.

CONCLUSION

The Court is respectfully requested to grant Mr. Mackby's petition to resolve all or some of the important questions presented here.

Dated: November 13, 2003

Respectfully submitted,

PATRIC HOOPER
HOOPER, LUNDY & BOOKMAN, INC.
Attorneys for Petitioner,
Peter Mackby

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, *Plaintiff-Appellee,* v. PETER MACKBY, *Defendant-Appellant.*	No. 02-16778 D.C. No. CV-98-01310-SBA ORDER AND OPINION

Appeal from the United States District Court
for the Northern District of California
Saundra B. Armstrong, District Judge, Presiding

Argued and Submitted
May 15, 2003 – San Francisco, California

Memorandum Filed June 3, 2003
Memorandum Withdrawn August 12, 2003
Opinion Filed August 12, 2003

Before: Michael Daly Hawkins and William A. Fletcher, Circuit Judges, and Samuel P. King,* Senior District Judge.

Opinion by Judge William A. Fletcher

COUNSEL

Patric Hooper, Hooper, Lundy & Bookman, Los Angeles, California, for the defendant-appellant.

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* The Honorable Samuel P. King, Senior District Judge for Hawaii, sitting by designation.

Sara Winslow, Office of the United States Attorney, San Francisco, California, for the plaintiff-appellee.

ORDER

Appellee's request for publication, filed June 10, 2003, is GRANTED.

This court's memorandum disposition, filed June 3, 2003, is hereby withdrawn and replaced with the following opinion.

Appellant's petition for panel rehearing and petition for rehearing en banc, filed July 7, 2003 are denied as moot.

OPINION

W. FLETCHER, Circuit Judge:

In 1999, the United States won a civil judgment under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, against Peter Mackby, the owner and managing director of a physical therapy clinic, for submitting false Medicare claims. We affirmed Mackby's liability but remanded for a determination of whether $729,454.92 in civil penalties and treble damages violated the Excessive Fines Clause of the Eighth Amendment. *United States v. Mackby,* 261 F.3d 821 (9th Cir. 2001) [hereinafter *Mackby I*]. On remand, the district court upheld the full judgment, concluding that it was not grossly disproportional to the gravity of Mackby's offense. *United States v. Mackby,* 221 F. Supp. 2d 1106 (N.D. Cal. 2002) [hereinafter *Mackby II*]. We now affirm.

I. Background

Mackby, who is neither a physician nor a physical therapist, managed and owned the Asher Clinic, a physical therapy clinic in Larkspur, California. The clinic provided physical therapy services to Medicare patients under Medicare Part B. Medicare Part A, not at issue here, provides hospital insurance benefits to the elderly and disabled. 42 U.S.C. § 1395d; 42 C.F.R. § 406. Medicare Part B is a voluntary insurance program that pays a portion of the costs of some services not covered by Part A. 42 U.S.C. § 1395k; 42 C.F.R. § 410. Part B pays for physical therapy in two instances: (1) when rendered by a physician, a qualified employee of a physician, or a physician-directed clinic; or (2) when rendered by a qualified physical therapist in independent practice ("PTIP").[1] 42 C.F.R. § 410.60(a) (1996) (superseded). During the relevant time period, Medicare capped the amount it would pay a PTIP on behalf of any one patient. *Id.* § 410.60(c)(2). No payment limit existed for physical therapy provided by or under the supervision of a physician.

Prior to 1988, Mackby had a partner, Michael Leary, a licensed physical therapist. During their partnership, the Asher Clinic billed Medicare Part B for physical therapy provided to Medicare patients by therapists at the clinic

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[1] During the relevant time period, a physical therapist in independent practice was defined as one who engaged in the practice of physical therapy on a regular basis without the administrative and professional control of an employer, maintained an office at his or her own expense, furnished services in that office or in the patient's home, and treated and collected compensation from his or her own patients. 42 C.F.R. § 410.60(c)(1) (1996) (superseded); *Mackby I,* 261 F.3d at 824-25.

using Leary's Medicare personal identification number ("PIN"). During this period, the clinic was subject to the cap applicable to a PTIP. In June 1988, Mackby assumed sole control of the clinic and instructed the clinic's billing service to use the PIN of his father, Dr. Judson Mackby, in lieu of Leary's PIN for the clinic's Medicare Part B claims. Because the government was led to believe that Dr. Mackby was supervising physical therapy, it made payments to the clinic without regard to the cap. Dr. Mackby, however, did not provide or direct any medical services at the clinic and did not know his son was using his PIN. Mackby himself is a layperson and did not provide physical therapy or other medical services to patients.

In September 1996, Mackby obtained certification for the Asher Clinic as a rehabilitation agency eligible to make claims under Medicare Part A. From that point forward the clinic no longer billed Medicare Part B. Mackby sold the clinic in May 1997 for about $1.7 million.

In 1998, the United States brought a civil action against Mackby under the False Claims Act, 31 U.S.C. §§ 3729-3733, alleging that between 1992 and 1996 he caused 8499 false claims to be submitted to Medicare, resulting in payments totaling $331,078. The district court conducted a three-day bench trial and found that Mackby had violated the False Claims Act by knowingly submitting false Medicare claims using Dr. Mackby's PIN.

Although Mackby submitted 8499 claims totaling $331,078, the government sought damages only for those claims that exceeded Medicare's annual payment limit per

beneficiary for PTIPs.[2] Between 1992 and 1996 the clinic submitted 1459 such claims totaling $58,151.64. Based on those claims, the district court awarded treble damages under the FCA, 31 U.S.C. § 3729(a), of $174,454.92. In addition to treble damages, the FCA also provides for a fine of not less than $5000 and not more than $10,000 per claim. *Id.* The government sought and the district court awarded the minimum statutory fine of $5000 per claim for 111 of the claims, representing one claim per beneficiary per year, for a total civil fine of $550,000. The total judgment against Mackby equaled $729,454.92.

We affirmed Mackby's liability, holding that Mackby had knowingly caused false Medicare claims to be submitted. *Mackby I,* 261 F.3d at 829. We further held that both the treble damages and the civil monetary penalty provided for in the FCA are, at least in part, punitive, and therefore subject to the Eighth Amendment Excessive Fines Clause. *Id.* at 830-31. We remanded to the district court to consider the constitutionality of the judgment against Mackby. *Id.* at 831.

Following the Supreme Court's decision in *United States v. Bajakajian,* 524 U.S. 321, 334 (1998), the district court considered whether the judgment is "grossly disproportional to the gravity of a defendant's offense." The court concluded (1) that Mackby was not involved in other illegal activities; (2) that taking into account all 8499 false Medicare claims totaling $331,078 caused by Mackby and

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[2] In 1992 and 1993 the limit was $750 per year. From 1994 through 1996 the limit was $900 per year. 42 C.F.R. § 410.60(c)(2) (1996) (superseded).

the $10,000 maximum penalty per claim authorized by the FCA, Mackby faced a maximum civil penalty of nearly $85 million and a maximum treble damage award of nearly $1 million; and (3) that the government suffered significant harm as a result of Mackby's false claims. *Mackby II,* 221 F. Supp. 2d at 1109-13. Weighing the gravity of the offense and the amount of the judgment, the court found the size of the judgment "necessary and appropriate for purposes of deterrence," *id.* at 1114, and held that it did not violate the Excessive Fines Clause, *id.* at 1107.

We review de novo whether a fine is unconstitutionally excessive. *Bajakajian,* 524 U.S. at 337, n.10.

II. Discussion

In *United States v. Bajakajian,* 524 U.S. 321 (1998), the Supreme Court established the standard for evaluating challenges under the Excessive Fines Clause: "[A] punitive forfeiture violates the Excessive Fines Clause if it is grossly disproportional to the gravity of a defendant's offense." *Id.* at 334. Bajakajian had attempted to leave the country with $357,144 in legally obtained currency. He pled guilty to failing to report that he was transporting more than $10,000 outside the United States, as required by 31 U.S.C. § 5316(a)(1)(A). *Id.* at 325. The district court imposed three years of probation and a $5000 fine, and concluded that the full $357,144 was subject to criminal forfeiture. The district court, however, found that full forfeiture would have been "extraordinarily harsh" and "grossly disproportionate" to the offense, and it ordered a forfeiture of $15,000 in addition to the fine and probation. *Id.* at 326.

The government appealed, and the Supreme Court held that forfeiture of the full amount violated the Eighth Amendment's ban on excessive fines. The Court first held that the forfeiture was punitive and constituted a "fine" subject to the Eighth Amendment. *Id.* at 328. The Court then considered the severity of Bajakajian's offense and its relation to other criminal activity, the maximum criminal penalty he faced, and the harm he caused. *Id.* at 337-39. It used these considerations to weigh the gravity of the crime against the amount of the forfeiture and concluded that a $357,144 forfeiture was grossly disproportional to the gravity of the offense and therefore unconstitutional. *Id.* at 339-40.

Bajakajian involved a criminal forfeiture, but the Court had previously concluded that civil forfeitures fall within the scope of the Eighth Amendment. *See Hudson v. United States,* 522 U.S. 93, 103 (1997). In *Mackby I,* we held that both the treble damages and the civil penalty assessed against Mackby were, at least in part, punitive and therefore subject to the Excessive Fines Clause. *Mackby I,* 261 F.3d at 830-31.

Bajakajian does not mandate the consideration of any rigid set of factors in deciding whether a punitive fine is "grossly disproportional to the gravity of a defendant's offense." We have, nevertheless, looked to factors similar to those used by the Court in *Bajakajian* in our Excessive Fines Clause cases. In *United States v. 3814 NW Thurman Street,* 164 F.3d 1191, 1197-98 (9th Cir. 1999), we held unconstitutional a civil forfeiture of $200,686.18 in connection with false statements made in a loan application. We noted that there was an absence of other related illegal activity, that the fine was far out of proportion with the

criminal penalties available under the Sentencing Guidelines for violating the underlying criminal statutes, and that the harm caused was minimal because neither the creditors nor the government suffered any actual loss. *Id.* at 1197-98. In *Balice v. United States Department of Agriculture,* 203 F.3d 684, 698-99 (9th Cir. 2000), we upheld a $225,500 civil fine for violations of a federal Almond Marketing Order. Our Excessive Fines Clause inquiry focused on the maximum possible penalty authorized by Congress and the fact that the defendant made an illegal profit from his activity somewhat larger than the fine itself. In *Vasudeva v. United States,* 214 F.3d 1155, 1161-62 (9th Cir. 2000), we upheld civil monetary penalties of $13,200 and $39,840 for trafficking in food stamps. We held that because trafficking in food stamps is a serious offense that defrauds the government and because the defendants could have elected permanent disqualification from the food stamp program instead of the monetary penalties, the fines were not excessive.

Today, we hold that the $729,454.92 judgment against Mackby does not violate the Excessive Fines Clause. The size of the penalty is not grossly disproportional to Mackby's level of culpability and the harm he caused. Mackby used a false Medicare PIN number to procure Medicare payments for which he was not eligible. As we explained in *Mackby I,* "[i]t is the representation of Dr. Mackby's involvement that is 'false.'" 261 F.3d at 827. Although the government did not seek damages for all of the claims, the district court found that Mackby submitted 8499 claims using Dr. Mackby's PIN. Since the use of the PIN led to liability, all 8499 claims constitute violations of the FCA. Furthermore, although the government sought damages only for the claims that exceeded the PTIP cap,

Mackby did not actually qualify as a PTIP after the departure of Leary in 1988 and thus was not eligible to receive any Medicare funds, let alone funds that exceeded the cap. *See Id.* at 829.

In *Bajakajian,* the Court found it significant that Bajakajian's crime was merely failing to report currency that was lawfully his and that he intended to use for a lawful purpose. 524 U.S. at 338. The Court noted that Bajakajian did not fit into the class persons for whom the forfeiture statute was principally designed – money launderers, drug traffickers, and tax evaders. *Id.* The False Claims Act, however, targets those who knowingly make a false claim for payment to the government. *See* 31 U.S.C. 3729(a)(1); *see also United States ex rel. Hagood v. Sonoma County Water Agency,* 929 F.2d 1416, 1421 (9th Cir. 1991) ("[W]hat constitutes the offense [under the False Claims Act] is not intent to deceive but knowing presentation of a claim that is either 'fraudulent' or simply 'false.' "). Mackby, who submitted claims using a false PIN number, therefore falls among the class of persons targeted by the Act.

The penalties available under the FCA provide another guide to Mackby's level of culpability. *See Bajakajian,* 524 U.S. at 338. The possible penalty available under the FCA is instructive but not dispositive of the constitutional question. *See id.* at 336 (stating that "judgments about the appropriate punishment for an offense belong in the first instance to the legislature," but holding that grossly disproportional fines are nonetheless unconstitutional). The fact, however, that Congress provided for treble damages and an automatic civil monetary penalty per false claim shows that Congress believed that making a false claim to the government is a serious offense. *See*

S. Rep. No. 99-345, at 17 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5282 (noting, in raising the statutory penalty to $10,000 per claim, "that defrauding the Government is serious enough to warrant an automatic forfeiture"). We may properly consider the maximum penalty prescribed by Congress as part of our Excessive Fines Clause inquiry. *See Balice,* 203 F.3d at 699 (holding that a $225,500 penalty for illegal almond sales was not excessive in part because the maximum authorized penalty was $528,000); *United States v. Emerson,* 107 F.3d 77, 80-81 (1st Cir. 1997) (holding that where a pilot made 37 unlawful charter flights without holding the proper FAA certificate a $5000 fine per flight was not excessive, and relying in part on the fact that the statutory maximum penalty was $10,000 per flight). Had the government sought damages for all 8499 claims, Mackby would have faced a maximum civil penalty of $84,990,000 ($10,000 per false claim). 31 U.S.C. § 3729(a). Furthermore, because the false claims resulted in payment of $331,078, the maximum treble damage award was $993,234. *Id.* The substantial difference between the actual judgment against Mackby – treble damages of $174,454.92 and a civil penalty of $555,000 – and the maximum available penalties weighs against a finding of gross disproportionality.

Mackby urges us to compare the judgment against him to the fine he would have faced had he been criminally convicted under the False Claims Act, 18 U.S.C. § 287. After calculating the maximum penalty under the Sentencing Guidelines (assuming the amount of loss equals $58,151.64, which represents the claims exceeding the PTIP cap), Mackby argues that the Guideline fine range is only $7500 to $75,000, which even at the high end is an order of magnitude less than the civil judgment.

Mackby's argument, however, does not take sufficiently into account the fact that his hypothetical criminal sentence could potentially include a term of imprisonment of 37-46 months, as well as restitution for the full amount of the loss.

Mackby focuses only on the disparity between the criminal fine available under the Guidelines and the judgment against him, but when courts have compared civil judgments with criminal penalties for the same conduct, they have considered the full criminal penalty. *See Bajakajian,* 524 U.S. at 338; *Thurman Street,* 164 F.3d at 1197. In both *Bajakajian* and *Thurman Street,* the maximum penalty the defendant faced for the underlying offense under the Sentencing Guidelines was a $5000 fine and 6 months in prison. *Bajakajian,* 524 U.S. at 338; *Thurman Street,* 164 F.3d at 1197. In neither case did the Guidelines require imprisonment. The Supreme Court held that the criminal penalty available under the Guidelines "confirmed a minimal level of culpability." *Bajakajian,* 524 U.S. at 339. The substantially greater criminal penalties that Mackby hypothetically could have faced for his conduct do not "confirm a minimal level of culpability." *See id.*

Mackby's false claims also harmed the government, both in the form of monetary damages and harm to the administration and integrity of Medicare. The fact that Mackby's clinic actually performed the physical therapy for which he claimed reimbursement does not eliminate the government's injury. Damages under the FCA flow from the false statement. "Ordinarily the measure of the government's damages [under the FCA] would be the amount that it paid out by reason of the false statements over and above what it would have paid if the claims had

been truthful." *United States v. Woodbury,* 359 F.2d 370, 379 (9th Cir. 1966). The falsity here was not Mackby's representation that patients had received physical therapy, but the use of his father's PIN to obtain payments to which he was not entitled. Had Mackby been truthful, the government would have known that he was entitled to nothing because he was neither a doctor nor a physical therapist in private practice. In the legislative history to the FCA, Congress specifically rejected a "no harm, no foul" argument: "A false claim for reimbursement under the Medicare, Medicaid or similar program is actionable under the act, . . . and such claim[ ] may be false even though the services are provided as claimed if, for example, the claimant is ineligible to participate in the program. . . . " S. Rep. No. 99-345, at 9, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5275.

The government has a strong interest in preventing fraud, and the harm of such false claims extends beyond the money paid out of the treasury. *See U.S. ex rel. Rosales v. San Francisco Housing Auth.,* 173 F. Supp. 2d 987, 1019-20 (N.D. Cal. 2001) (discussing Congress's purpose in the FCA to maintain public confidence in the government by protecting against fraud). Fraudulent claims make the administration of Medicare more difficult, and widespread fraud would undermine public confidence in the system. *See* S. Rep. No. 99-345, at 2-3, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5267-68 (noting the pervasiveness of fraud in government in programs, including entitlement programs, and the difficulty in deterring fraud).

Finally, we view some part of the judgment against Mackby as remedial.[3] Before Congress amended the FCA in 1986, the Act provided for double damages and a $2000 maximum civil penalty per false claim. Discussing this provision in 1976, the Supreme Court concluded: "'We think the chief purpose of the [Act's civil penalties] was to provide for restitution to the government of money taken from it by fraud, and that the device of double damages plus a specific sum was chosen to make sure that the government would be made completely whole.'" *United States v. Bornstein,* 423 U.S. 303, 314 (1976) (quoting *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 551-52 (1943)). *See also Noriega-Perez v. United States,* 179 F.3d 1166, 1174 (9th Cir. 1999) (holding that a $96,000 civil fine for counterfeit immigration documents was not excessive when the investigation cost approximately $48,000). The government admits it cannot quantify the expenses incurred in pursuing the claim against Mackby. But given the Supreme Court's conclusion that the earlier provision of the FCA for double damages plus a civil penalty was designed to be largely remedial, we can safely conclude that under the current statutory scheme at least some portion of the award that was over and above the amount of money actually paid out by the government was similarly remedial.

Considering both Mackby's culpability and the harm caused by his offense, we hold that the full $729,454.92

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[3] In *Mackby I,* we held that the both the civil penalty and the treble damage provision of the FCA were, at least in part, punitive. We do not decide here precisely what portion of either component of the judgment is remedial and what portion punitive.

judgment against Mackby is not grossly disproportional to the gravity of his offense. The judgment of the district court is therefore

AFFIRMED.

JUDGMENT

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 02-16778
CT/AG#: CV-98-01310-SBA

UNITED STATES OF AMERICA,

Plaintiff-Appellee

v.

PETER MACKBY

Defendant-Appellant

APPEAL FROM the United States District Court for the Northern Division of California (Oakland).

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Northern Division of California (Oakland) and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is AFFIRMED.

Filed and entered 8/12/03

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, *Plaintiff-Appellee,* v. PETER MACKBY, *Defendant-Appellant.*	No. 99-15605 D.C. No. CV-98-01310-SBA ORDER AND OPINION

Appeal from the United States District Court
for the Northern District of California
Saundra B. Armstrong, District Judge, Presiding

Argued and Submitted
December 12, 2000 – San Francisco, California

Filed August 16, 2001

Before: David R. Thompson, Diarmuid F. O'Scannlain, and A. Wallace Tashima, Circuit Judges.

Opinion by Judge Thompson

COUNSEL

Patric Hooper, Los Angeles, California, for the appellant.

Gail Killefer, Assistant United States Attorney, San Francisco, California, for the appellee.

ORDER

The government's petition for rehearing is granted. The opinion filed March 21, 2001 and published at 243 F.3d 1159 (9th Cir. 2001), is withdrawn. In its stead, the panel substitutes the opinion filed contemporaneously with this order.

OPINION

THOMPSON, Circuit Judge:

Peter Mackby, the owner and managing director of a physical therapy clinic called Asher Clinic, appeals the district court's civil judgment in favor of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733 (1994). After a three-day bench trial, the district court found that Mackby knowingly caused false claims to be submitted to Medicare between 1992 and 1996 by instructing the clinic's billing company and office manager to use his physician father's Provider Identification Number (PIN) on claim forms to bill for physical therapy services provided at the clinic.

The court awarded the United States a judgment of $729,454.92, based on a $5,000 civil penalty for one Medicare beneficiary claim per patient for each patient for whom Asher Clinic submitted Medicare claims which exceeded the annual monetary limit (111 claims x $5,000 = $555,000), plus treble damages for Medicare overpayments of $58,151.64 ($58,151.64 x 3 = $174,454.92).

We affirm the judgment of the district court as to the violation of the False Claims Act, but remand to the district court for its consideration of whether the statutory penalty and the treble damages awarded are unconstitutionally excessive under the Eighth Amendment.

I.

The Medicare Program is administered by the United States Department of Health and Human Services,

through the Health Care Financing Administration (HCFA). Medicare Part A, which is not at issue here, provides hospital insurance benefits to the elderly and disabled. Medicare Part B is a federally subsidized, voluntary insurance program that pays a portion of the cost of certain medical and other health services not covered by the Part A program, including some physical therapy services. Reimbursement for Medicare claims is made by the United States through HCFA. HCFA, in turn, contracts with private insurance carriers to administer and pay claims from the Medicare Trust Fund. In this capacity, the carriers act as fiscal intermediaries on behalf of HCFA. The Medicare fiscal intermediary involved in this case was Blue Shield of California.

Medicare pays for physical therapy services under Part B "when rendered by a physician, by a qualified employee of a physician or physician-directed clinic (whose services are rendered 'incident-to' a physician's services), or by a qualified physical therapist in independent practice." Medicare Bulletin (Chico, CA), Mar. 1993, at 22. A "physical therapist in independent practice" (PTIP) is defined in relevant part as one who "render[s] services free from the administrative and professional control of an employer such as a physician, institution, agency, etc." *Id.* at 23; *see also* 42 C.F.R. § 410.60(c)(1)(ii) (1996). Medicare caps the amount it will pay a PTIP on behalf of any one Medicare beneficiary in any calendar year. From 1992 through 1993, the limit was $750 per year. From 1994 through 1996, the limit was $900 per year. 42 C.F.R. § 410.60(c)(2)(iii) & (iv) (1996). There is no payment limit on physical therapy services furnished by or under the supervision of a physician or incident to a physician's services.

In 1982, defendant Peter Mackby entered into a partnership with Michael Leary, a licensed physical therapist, for the purposes of owning and operating Asher Clinic in Larkspur, California. During the partnership, Asher Clinic billed Medicare Part B for services provided to Medicare patients by various physical therapists employed by Asher Clinic, using Leary's PIN. Medicare checks were sent to Asher Clinic made payable to Michael Leary, RPT.

In June 1988, Mackby bought Leary's interest in the clinic. He incorporated the business under the name "M1 Enterprises," and became the sole shareholder of the corporation as well as its President, Chief Financial Officer, Treasurer and Secretary. Mackby, a layperson, did not provide any physical therapy or other services to patients.

After he assumed sole control of the clinic, Mackby instructed Medicom, the clinic's billing service, to substitute the PIN of his father, M. Judson Mackby, M.D. (Dr. Mackby), for Leary's PIN on Asher Clinic's Medicare Part B claims. Mackby also told Maridy Barnett, the clinic's office manager, to use his father's PIN in billing third-party payers, including Medicare.

The court found that Dr. Mackby did not know that his PIN was being used by Asher Clinic to bill Medicare for physical therapy services. It is undisputed that Dr. Mackby never provided medical services at or for Asher Clinic, never referred any patients to the clinic and was never involved with the care or treatment of its patients. A little over a year after M1 Enterprises became the owner of Asher Clinic, Dr. Mackby became the corporation's

Secretary. Before then, he had no affiliation with the clinic.

Approximately twenty percent of Asher Clinic's patients were Medicare patients. From 1988, when Mackby's corporation became sole owner of the clinic, until 1996, Asher Clinic submitted claims to Medicare for physical therapy services using Dr. Mackby's PIN. That PIN was placed in boxes 24k and 33 of HCFA 1500, the Medicare claim form used to request reimbursement. Medicare reimbursement checks were made payable to "M. Judson Mackby, M.D." and sent to the Asher Clinic address. Asher Clinic used a rubber endorsement stamp containing Dr. Mackby's name to endorse and deposit Medicare payments to its bank account. The Explanation of Medicare Benefits ("EOMBs") sent by Medicare to its beneficiaries identified Dr. Mackby as the rendering provider of the services. EOMBs, Medicare Bulletins and Medicare audit inquiries were sent to Asher Clinic and addressed to Dr. Mackby as well.

The district court found that Mackby's testimony that he relied on the advice of a lawyer in using his father's PIN was not credible. The court further found that because Dr. Mackby's PIN was placed in boxes 24k and 33 of the reimbursement form, Medicare was led to believe that Dr. Mackby was providing the physical therapy services for which Asher Clinic was billing, or at the very least that such services were rendered "incident to" his supervision.

In March 1996, Medicare wrote to Dr. Mackby using the Asher Clinic address and requested medical records for purposes of an audit. The district court found that shortly thereafter, Mackby expended considerable effort to have Asher Clinic meet the conditions of Medicare Part A

eligibility as a "rehabilitation agency," which required the clinic to take on additional administrative expenses. The clinic was surveyed by Medicare in July 1996 and accepted as a rehabilitation agency in September of that year. Thereafter, Asher Clinic no longer billed for its physical therapy services under Medicare Part B, but instead billed for such services under Part A as a "rehabilitation agency."

M1 Enterprises sold Asher Clinic in May 1997 for $1,675,000. The complaint in this case was filed in March 1998, the bench trial ended with a judgment entered in March 1999, and this appeal followed. Mackby challenges his liability and the amount of the district court's money judgment. We discuss each in turn.

II.

To establish a cause of action under the False Claims Act (FCA), 31 U.S.C. § 3729(a)(1), the government must prove three elements: (1) a "false or fraudulent" claim; (2) which was presented, or caused to be presented, by the defendant to the United States for payment or approval; (3) with knowledge that the claim was false. 31 U.S.C. § 3729(a)(1) (1994).

A. Falsity of Claim

The parties do not dispute that a claim for Medicare payment is a "claim" under the FCA. *See United States ex rel. Aflatooni v. Kitsap Physicians Servs.*, 163 F.3d 516 (9th Cir. 1999). The FCA does not define what types of claims are "false." However, a claim may be false even if the services billed were actually provided, if the purported provider did not actually render or supervise the service.

See Peterson v. Weinberger, 508 F.2d 45, 52 (5th Cir. 1975) (holding that a defendant was liable under the FCA although services billed to Medicare were performed by qualified people, where the claim forms falsely certified that the defendant was the provider); S. Rep. No. 99-345, at 9 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5274 (citing *Peterson* to support the proposition that a false claim for Medicare reimbursement is actionable).

According to the Medicare fiscal intermediary's bulletins, and as found by the district court, box 24k on the HCFA-1500 form is to be filled in with the assigned PIN for the performing physician or supplier. Medicare Special Notice (Medicare Publications, San Francisco, CA), Aug. 1995, at 5; Medicare Bulletin (Chico, CA), Mar. 1993, at 18. Box 33 is for the PIN of the billing entity, which can be either an individual or group, and is labeled "Physician's, Supplier's Billing Name, Address, ZIP Code & Phone #; PIN #, GRP #." Medicare Special Notice (Medicare Publications, San Francisco, CA), Aug. 1995, at 6; Medicare Bulletin (Chico, CA), Mar. 1993, at 19-20; HCFA-1500 (Dec.1990). The district court found, and the parties do not dispute, that Dr. Mackby's PIN was inserted in boxes 24k and 33 on the Asher Clinic forms.

While the purpose of box 24k is not specified on the form itself, Medicare bulletins sent to Asher Clinic state that the box is to be used for the PIN of the performing physician or supplier. Placing Dr. Mackby's PIN in box 24k indicated that Dr. Mackby was the performing physician or supplier and therefore constituted a false statement. Box 33 is clearly labeled as requiring the PIN or group number of the physician or supplier providing the treatment, and Dr. Mackby was neither of these. Therefore,

placing his PIN number in this box was a false statement as well.

Mackby argues that the falsity of the claims submitted by Asher Clinic depends "solely upon the technical interpretation of the instructions for the claims" because the claims accurately describe physical therapy services that were actually rendered. However, the fact that physical therapy services were actually rendered does not negate Asher Clinic's false representation that Dr. Mackby performed the services described on the claim forms or that those services were rendered incident to Dr. Mackby's supervision. It is the representation of Dr. Mackby's involvement that is "false," and that falsity is sufficient to satisfy the first element of an FCA claim. *See Peterson,* 508 F.2d at 52 (a Medicare claim may be false even if services were provided).

Mackby also argues that to sustain an FCA action, a claim must be found to be false under "any plausible interpretation," citing *United States v. Race,* 632 F.2d 1114, 1120 (4th Cir. 1980) and *United States v. Anderson,* 579 F.2d 455, 460 (8th Cir. 1978). These cases state that in a *criminal* FCA proceeding, when there are ambiguities as to the falseness of a claim, "the government must negative any reasonable interpretation that would make the defendant's statement factually correct." *Anderson,* 579 F.2d at 460. The *Race* and *Anderson* cases are distinguishable from the present case in that they are criminal cases. In those cases, the government had to prove falsity "beyond a reasonable doubt." In contrast, the burden of proof in the present case is a "preponderance of the evidence."

Furthermore, *Anderson* specifically noted that its standard applied in light of ambiguities in the language of

the defendant's certifications to the government. 579 F.2d at 459-60. And, in *Race,* the court held that the government in effect had conceded that the defendant's construction of the contract language was reasonable; as a result, the government could not negate "any reasonable interpretation that would make the defendant's statement factually correct." *Race,* 632 F.2d at 1120 (quoting *Anderson,* 579 F.2d at 460). In the present case, the government did not concede that Mackby's interpretation was reasonable, and the district court did not find any ambiguity as to what Mackby claimed. The district court found that the instructions for box 24k required the PIN of the performing physician or supplier, that those for box 33 required the PIN of the billing entity and the identifying information for the physician or supplier, and that Dr. Mackby's PIN did not satisfy either requirement. These findings by the district court are not clearly erroneous.

B. Causation

The causation element under 31 U.S.C. § 3729 is satisfied if a person "presents, or causes to be presented," a false or fraudulent claim to the United States for payment or approval. 31 U.S.C. § 3729(a)(1) (1994). The FCA reaches "any person who knowingly *assisted in* causing the government to pay claims which were grounded in fraud, without regard to whether that person had direct contractual relations with the government." *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 544-45 (1943) (emphasis added). Thus, a person need not be the one who actually submitted the claim forms in order to be liable. *See United States v. Krizek,* 111 F.3d 934, 942 (D.C. Cir. 1997) (holding that a doctor was liable for false claims prepared by his wife, where he "delegated to his wife authority to submit

claims on his behalf" and "utterly" failed to review the false submissions).

Mackby argues that by instructing Medicom, Asher Clinic's Medicare billing service, and Ms. Barnett, Asher Clinic's office manager, to use Dr. Mackby's PIN, he did not "cause" the claims to be submitted to Medicare because he did not tell Medicom or Ms. Barnett *where* to place Dr. Mackby's PIN number on the forms. This argument lacks merit. Mackby told Medicom and Ms. Barnett to "substitute" Dr. Mackby's PIN for Leary's. In so doing, he caused the claims to be submitted with false information. Medicom and Ms. Barnett acted pursuant to Mackby's instructions, just as the doctor's wife acted pursuant to the doctor's instruction in *Krizek*. The causation element was established by a preponderance of the evidence.

C. Knowledge of the Claims' Falsity

Under the FCA, " 'knowing' and 'knowingly' mean that a person, with respect to information – (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required." 31 U.S.C. § 3729(b) (1994). *See also United States ex rel. Hochman v. Nackman,* 145 F.3d 1069, 1073 (9th Cir. 1998). "The requisite intent is the knowing presentation of what is known to be false." *United States ex rel. Hagood v. Sonoma County Water Agency,* 929 F.2d 1416, 1421 (9th Cir. 1991). "Known to be false" does not mean scientifically untrue, but "a lie." *United States ex rel. Anderson v. N. Telecom, Inc.,* 52 F.3d 810, 815-16 (9th Cir. 1995) (quoting

Wang v. FMC Corp., 975 F.2d 1412, 1421 (9th Cir. 1992)) (internal quotation marks omitted).

"Protection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law. . . . " *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51, 63 (1984). Participants in the Medicare program have a duty to familiarize themselves with the legal requirements for payment. *Id.* at 64.

The evidence established that Mackby was the managing director of the clinic. He was responsible for day-to-day operations, long-term planning, lease and build-out negotiations, personnel, and legal and accounting oversight. It was his obligation to be familiar with the legal requirements for obtaining reimbursement from Medicare for physical therapy services, and to ensure that the clinic was run in accordance with all laws. His claim that he did not know of the Medicare requirements does not shield him from liability. By failing to inform himself of those requirements, particularly when twenty percent of Asher Clinic's patients were Medicare beneficiaries, he acted in reckless disregard or in deliberate ignorance of those requirements, either of which was sufficient to charge him with knowledge of the falsity of the claims in question. *See Krizek,* 111 F.3d at 942 (in failing "utterly" to review false submissions prepared by his wife, doctor acted with reckless disregard).

Mackby argues he did not disregard the truth or falsity of the claims, but rather asked Ms. Barnett, his office manager, to contact Medicare in 1988 when he bought the business from Leary, to find out the appropriate payment rules. In addition, Mackby points out, in 1991 Ms. Barnett inquired about changing Asher Clinic's billing

number to that of a physical therapist who worked at the clinic, a request which was denied by Blue Shield, the clinic's Medicare fiscal intermediary. She made a second request in 1995, which was also denied. These arguments do not negate the fact that Mackby was required to operate Asher Clinic in a legal manner at all times. The clinic's sporadic efforts to change its billing practices does not justify the clinic's eight year improper use of Dr. Mackby's PIN on Medicare claim forms.

Mackby also argues he had no wrongful motive in representing that his father provided the services reflected on the claim forms. He points out that because Blue Shield believed the physical therapy services were provided by a physician, it did not inform the clinic when the physical therapy cap for PTIPs had been reached for particular patients. Therefore, he argues, Asher Clinic was actually deprived of the opportunity to bill its patients at its full rates. This argument fails. If Asher Clinic had been held to the billing cap and had tried to bill its patients directly for amounts in excess of the cap, the patients could have, and it seems reasonable that they very well would have, left to seek services from physicians or physician-run clinics where the cap did not apply, so that they could receive Medicare benefits covering the full amount of physical therapy services, rather than pay Asher Clinic out of their own pockets the amounts billed in excess of the cap.

Mackby's argument that he had no motive to present false claims because he could have easily given an ownership interest to one of Asher Clinic's physical therapists also fails. Even if giving a physical therapist an ownership interest in the clinic could have qualified Asher Clinic for Medicare billing as a PTIP, that status would have required a cap on reimbursement. In contrast, Asher Clinic's

status as an apparently physician-run practice enabled it to avoid the cap altogether. The district court did not clearly err by finding that Mackby knowingly presented false Medicare claims.

Because the evidence established all of the elements of Mackby's violation of the FCA, the district court properly concluded that he violated that statute. We turn next to a consideration of the district court's computation of the money judgment, and whether the amount of that judgment violates the Excessive Fines Clause of the Eighth Amendment.

D. Application of the Excessive Fines Clause

In its money judgment, the district court included a civil penalty of $555,000. Mackby contends this penalty violates the Excessive Fines Clause of the Eighth Amendment.

A fine is unconstitutionally excessive if (1) the payment to the government constitutes punishment for an offense, and (2) the payment is grossly disproportionate to the gravity of the defendant's offense. *United States v. Bajakajian,* 524 U.S. 321, 327-28 (1998). *Bajakajian* did not deal with a civil sanction but rather with the criminal forfeiture of property involved in the unreported transportation of over $10,000 in currency out of the country. However, prior to *Bajakajian,* the Supreme Court held that civil fines fall within the scope of the Eighth Amendment. *See Hudson v. United States,* 522 U.S. 93, 103 (1997) ("The Eighth Amendment protects against excessive civil fines, including forfeitures.") (citing *Alexander v. United States,* 509 U.S. 544 (1993) and *Austin v. United States,* 509 U.S. 602 (1993)). In addition, we have applied the first

part of *Bajakajian*'s rule, examining the punitive or remedial nature of a penalty, to civil sanctions. *See Louis v. Comm'r of Internal Revenue,* 170 F.3d 1232, 1236 (9th Cir. 1999) (quoting *Austin,* 509 U.S. at 610, and citing *Bajakajian,* 524 U.S. at 329 n.4). We have held that "a civil sanction that cannot fairly be said solely to serve a remedial purpose, but rather can only be explained as also serving either retributive or deterrent purposes, is punishment." *Wright v. Riveland,* 219 F.3d 905, 915 (quoting *Austin,* 509 U.S. at 610). In determining whether a civil sanction is punitive or remedial, "the court considers factors such as the language of the statute creating the sanction, the sanction's purpose(s), the circumstances in which the sanction can be imposed, and the historical understanding of the sanction." *Louis,* 170 F.3d at 1236 (citing *Bajakajian,* 524 U.S. at 327-32).

The language of the FCA does not specify whether its sanction of $5,000 to $10,000 per claim is meant to be punitive or remedial. *See* 31 U.S.C. §§ 3729-3733 (1994). However, the sanction clearly has a punitive purpose. No damages to the government need be shown. *Hagood,* 929 F.2d at 1421 (citing *Rex Trailer Co. v. United States,* 350 U.S. 148, 153 n.5 (1956)). Furthermore, in addition to the sanction, treble damages are recoverable, demonstrating that the sanction's purpose is not to provide a form of damages. *See Wright,* 219 F.3d at 915 (stating that deductions from inmates' funds which were made "regardless of whether an inmate committed an offense for which restitution is appropriate and regardless of whether the inmate had already been ordered to pay court-ordered restitution at sentencing" served the goal of deterrence and therefore constituted punishment for Excessive Fines Clause purposes). In addition, the legislative history of the False

Claims Amendments Act of 1986 indicates that the statute has a deterrent purpose. For example, the Senate Report states that the FCA "is a much more powerful tool in deterring fraud" than common-law contract remedies. S. Rep. No. 99-345, at 4 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5269.

The fact that the FCA's purpose is at least in part punitive has been recognized by the Supreme Court. In *United States v. Bornstein,* 423 U.S. 303, 309 n.5 (1976) (citations omitted), the Court stated, "According to its sponsor, the False Claims Act was adopted 'for the purpose of punishing and preventing . . . frauds.'" Additionally, in *Austin,* 509 U.S. at 619, the Court noted that an "innocent owner" defense was one factor in the Court's determination that the statute in question was in part punitive and therefore subject to the Excessive Fines Clause.

We conclude the civil sanctions provided by the False Claims Act are subject to analysis under the Excessive Fines Clause because the sanctions represent a payment to the government, at least in part, as punishment. Inquiry must be made, therefore, to determine whether the payment required by the district court is so grossly disproportionate to the gravity of Mackby's violation as to violate the Eighth Amendment. *See Bajakajian,* 524 U.S. at 327-28, 334. For purposes of that inquiry, the record must be further developed by the district court. For example, one of the factors to be considered is whether a fine as large as that imposed by the district court is required to achieve the desired deterrence. That and other factors that may be relevant to the inquiry should be addressed in the first instance by the district court. Accordingly, we remand this case to the district court for a determination of whether the $555,000 fine was

unconstitutionally excessive. *See Wright,* 219 F.3d at 918-19 (remanding to the district court for a "fact-intensive inquiry" to determine the issue of excessiveness).

That brings us to the final issue – whether the district court's treble damage award is also subject to an Excessive Fines Clause analysis. Although the Supreme Court has not directly addressed the question whether treble damages under the FCA are punitive, thus requiring an Excessive Fines Clause analysis, it has stated that "[t]he very idea of treble damages reveals an intent to punish past, and deter future, unlawful conduct." *Texas Indus., Inc. v. Radcliff Materials, Inc.,* 451 U.S. 630, 639 (1981). Although that statement was made in the context of an antitrust case, it was later cited by the Supreme Court in *Vermont Agency of Natural Res. v. United States ex rel. Stevens,* 529 U.S. 765, 784-86, 120 S. Ct. 1858, 1869-70 (2000), to support the Court's argument that treble damages under the FCA, at least in combination with the Act's civil penalty provision, are "essentially punitive in nature," for the purposes of determining state liability in a qui tam suit.

Moreover, the Supreme Court has held numerous times that treble damages pursuant to antitrust statutes are not purely remedial. *See, e.g., Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.,* 473 U.S. 614, 635 (1985) ("The treble-damages provision wielded by the private litigant is a chief tool in the antitrust enforcement scheme, posing a crucial deterrent to potential violators," citing *Perma Life Mufflers, Inc. v. Int'l Parts Corp.,* 392 U.S. 134, 138-39 (1968)); *Am. Soc'y of Mech. Eng'rs, Inc. v. Hydrolevel Corp.,* 456 U.S. 556, 575 (1982) ("[A]ntitrust treble damages were designed in part to punish past violations of the antitrust laws. . . . [T]reble damages were also

designed to deter future antitrust violations.") (citing *Texas Indus.*, 451 U.S. at 639). *But cf. Atlantic Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 331 n.1 (1990) (stating that the treble damages provision of the Clayton Act is a "remedial provision").

We conclude that the FCA's treble damages provision, at least in combination with the Act's statutory penalty provision, is not solely remedial and therefore is subject to an Excessive Fines Clause analysis under the Eighth Amendment. Accordingly, we remand to the district court for its consideration the question whether a treble damage award in this case would be unconstitutionally excessive. *See Wright*, 219 F.3d at 918-19.

In remanding this case to the district court to apply an excessive fines analysis to the civil penalty and treble damages portions of the case, we recognize that the amount of the civil penalty and the amount of treble damages need not be considered in isolation as if the other did not exist. To the contrary, the amount of one will no doubt bear upon the district court's excessive fines analysis with regard to the other. We express no opinion as to whether such an analysis would be appropriate in a case where only treble damages were awarded, or where the civil penalty was not of such a substantial magnitude as it presently is in this case.

III.

The district court's finding that Mackby violated the False Claims Act is AFFIRMED. The case is REMANDED to the district court for further development of the record to determine whether the civil penalty and treble damages presently contained in the district court's judgment violate

the Excessive Fines Clause of the Eighth Amendment. Each party shall bear its own costs for this appeal.

AFFIRMED in part and REMANDED.

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. PETER MACKBY, Defendant-Appellant.	No. 02-16778 D.C. No. CV-98-01310-SBA MEMORANDUM* (Filed Jun. 3, 2003)

Appeal from the United States District Court
for the Northern District of California
Saundra B. Armstrong, District Judge, Presiding

Argued and Submitted May 15, 2003

San Francisco, California

Before: HAWKINS and W. FLETCHER, Circuit Judges, and KING,** Senior District Judge.

In 1999, the United States won a civil judgment under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, against Peter Mackby, the former owner and managing director of the Asher Clinic, a physical therapy clinic in Larkspur, California, for submitting false Medicare claims. In *United States v. Mackby*, 261 F.3d 821 (9th Cir.

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Circuit rule 36-3.

** The Honorable Samuel P. King, senior District Judge for Hawaii, sitting by designation.

2001), we affirmed Mackby's liability but remanded for a determination of whether $729,454.92 in civil penalties and treble damages violated the Excessive Fines Clause of the Eighth Amendment. On remand the district court upheld the full $729,454.92 judgment, concluding that it was not grossly disproportional to the gravity of Mackby's offense. We review the question of whether a fine is constitutionally excessive de novo, *United States v. Bajakajian*, 524 U.S. 321, 337 n.10 (1998), and we affirm.

A fine violates the Excessive Fines Clause "if it is grossly disproportional to the gravity of a defendant's offense." *Id.* at 334. The essence of Mackby's offense was his use of someone else's Medicare personal identification number to procure Medicare payments for which he was not eligible. Although not dispositive, we may properly consider Congress's judgment about minimum and maximum penalties as a guide. *See Balice v. U.S. Dept't of Agric.*, 203 F.3d 684, 699 (9th Cir. 2000); *United States v. Emerson*, 107 F.3d 77, 80 (1st Cir. 1997). Had the government sought the minimum statutory penalty for each of the 1459 claims for which it sought damages, the fine would have been over $7 million.

If we do as Mackby urges and compare the judgment against him to the criminal penalties he would have faced had he been convicted under the criminal False Claims Act, 18 U.S.C. § 287, that comparison does not weigh in Mackby's favor. using Mackby's own calculations, under the Sentencing Guidelines he would face not only up to a $75,000 fine, but also restitution for the full amount of the false claims and a term of imprisonment of 37-46 months. *See Bajakajian*, 524 U.S. at 338 (comparing the civil judgment to the total criminal penalty); *United States v. 3814 NW Thurman Street*, 164 F.3d 1191, 1197 (9th Cir.

1999) (same). Even under the most lenient interpretation of the Guidelines, Mackby would face some mandatory prison time.

Finally, Makby's conduct was not harmless. The government has an interest in preserving the integrity of the Medicare system and protecting against fraud. Fraudulent claims, even when the medical services were actually performed, hinder the effective administration of Medicare. Comparing the size of Mackby's fine to the gravity of his offense, we conclude that the former is not grossly disproportional to the latter.

AFFIRMED.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,

Plaintiff,

v.

PETER MACKBY,

Defendant. /

No. C 98-1310 SBA

ORDER RE EXCESSIVE FINES CLAUSE

(Filed Sep. 3, 2002)

The United States ("Government") commenced this action against defendant, Peter Mackby, alleging violations of the False Claims Act, 31 U.S.C. § 3729. Following a three-day court trial, the Court found in favor of the Government and entered judgment against Mackby in the amount of $729,454.92. Mackby subsequently appealed to the Ninth Circuit Court of Appeals which, in a published opinion, affirmed this Court's finding of liability but remanded the action "for further development of the record to determine whether the civil penalty and treble damages presently contained in the district court's judgment violate the Excessive Fines Clause of the Eighth Amendment." *United States v. Mackby,* 261 F.3d 821, 831 (9th Cir. 2001). Having read and considered the briefs filed by the parties in connection with the remand, the Court finds that the judgment previously entered by the Court does not violate the Eighth Amendment.[1]

[1] This matter is suitable for disposition without a hearing. Fed. R. Civ. P. 78.

BACKGROUND

The facts of this case are set forth in the Ninth Circuit's opinion, and will only be briefly summarized herein. Mackby and his business partner, Michael Leary ("Leary"), managed and owned a physical therapy clinic known as the Asher Clinic. Prior to June 1988, the Asher Clinic billed Medicare Part B for physical therapy services provided to Medicare patients by various therapists employed by Asher Clinic, using Leary's personal identification number ("PIN").[2] Mackby and Leary became embroiled in a lawsuit. As part of the settlement, Mackby acquired Leary's interest and assumed sole control over the Asher Clinic in June 1988. Since Leary was no longer affiliated with the clinic, Mackby began submitting bills for Medicare Part B claims using the PIN of his physician-father, M. Judson Mackby, M.D. ("Dr. Mackby"). However, Dr. Mackby never provided medical services at or for Asher Clinic, referred any patients to the clinic, nor was he involved with the care or treatment of its patients. He was also unaware that his son was using his PIN to obtain

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[2] The Medicare program covers services through Part A and Part B. Part B, the only part at issue, provides for the payment of physical therapy services in two instances: (1) physical therapists in independent practice ("PTIP") or (2) physicians, who may personally provide physical therapy services, or through licensed and qualified professional employees when such services are "incident to" services rendered by the physician. Medicare caps the amount that a PTIP can bill on behalf of any one Medicare beneficiary in any calendar year. In contrast, there is no payment cap on physical therapy services furnished by a physician or incident to a physician's services. *See Mackby*, 261 F.3d at 824-25 (general discussion of Medicare Part B). The Asher Clinic was not qualified to bill Medicare as a PTIP. In addition, by falsely representing the Asher Clinic as a physician-run practice, Mackby was able to evade the cap on Medicare payments. *Id.* at 829.

payment of Medicare claims.[3] Mackby eventually sold the Asher Clinic in May 1997 for $1.7 million.

In March 1998, the Government filed the instant action against Mackby, alleging violations of the FCA. The Government claimed that Mackby violated the Act by directing his clinic to submit claims to Medicare for physical therapy services with an unauthorized provider number, to wit, the PIN which in actuality belonged to Dr. Mackby. During the time period encompassing 1992 to 1996, Mackby caused 8,499 false claims to be submitted to Medicare, resulting in payments totaling $331,078. A three-day bench trial took place in February 1999. After considering the evidence and testimony presented, the Court found in favor of the Government. (Pl.'s Am. Findings of Fact and Conclusions of Law ("FFCL") at 10, filed March 8, 1999.) The Court found that between 1992 and July 1996, the Asher Clinic submitted $58,151.64 in claims which exceeded Medicare's annual payment limit per beneficiary for PTIP's. (*Id.*; *see also supra* n.2.) Based on this figure, the Court imposed a treble damage award of $174,454.92. (*Id.*) The Court also imposed a civil penalty of $555,000.00 based on a minimum penalty of $5,000.00 per beneficiary per year that exceeded Medicare's annual payment limit for PTIPs, i.e., 111 claims. (*Id.*) On March 10, 1999, the Court entered judgment against Mackby in the amount of $729,454.92. (See Judgment, filed March 10, 1999.)

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[3] Mackby's suggestion in his opening memorandum that his father's testimony was "perjured or coerced" is unsubstantiated and wholly irrelevant to the instant proceedings. (Def.'s Opening Brief at 2.)

Mackby filed an appeal with the Ninth Circuit challenging his liability and the amount of the monetary judgment. The appellate court affirmed this Court's determination that Mackby had violated the FCA. *Mackby,* 261 F.3d at 829, 831 ("Because the evidence established all of the elements of Mackby's violation of the FCA, the district court properly concluded that he violated that statute."). With regard to the judgment, however, the Ninth Circuit remanded the action for the limited purpose of determining whether the civil penalty and treble damage award violates the Excessive Fines Clause of the Eighth Amendment. *Id.* at 831. The court stated:

> We conclude the civil sanctions provided by the False Claims Act are subject to analysis under the Excessive Fines Clause because the sanctions represent a payment to the government, at least in part, as punishment. *Inquiry must be made, therefore, to determine whether the payment required by the district court is so grossly disproportionate to the gravity of Mackby's violation as to violate the Eighth Amendment. [Citation] For purposes of that inquiry, the record must be further developed by the district court.* For example, one of the factors to be considered is whether a fine as large as that imposed by the district court is required to achieve the desired deterrence. That and other factors that may be relevant to the inquiry should be addressed in the first instance by the district court. Accordingly, we remand this case to the district court for a

> determination of whether the $555,000 fine was unconstitutionally excessive.

Mackby, 261 F.3d at 830 (emphasis added).[4]

The Ninth Circuit also concluded that the treble damage award is subject to an Excessive Fines Clause analysis, and remanded the action "to the district court for its consideration the question whether a treble damage award in this case would be unconstitutionally excessive." *Id.* at 830-31. However, the court noted that "the amount of the civil penalty and the amount of treble damages need not be considered as if the other did not exist. To the contrary, the amount of one will no doubt bear upon the district court's excessive fines analysis with regard to the other." *Id.* at 831. By Order of this Court, the parties have each submitted memoranda in connection with these issues.

LEGAL STANDARD

The Excessive Fines Clause of the Eighth Amendment prohibits the government from imposing "excessive fines" as punishment. *See* U.S. Const. amend. VIII. "A fine is unconstitutionally excessive if (1) the payment to the government constitutes punishment for an offense, and (2) the payment is grossly disproportionate to the gravity of the defendant's offense." *Mackby,* 261 F.3d at 830 (citing *United States v. Bajakajian,* 524 U.S. 321, 327-28 (1998)).

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[4] Under the FCA, a defendant may be liable for "a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains. . . . " 31 U.S.C. § 3729(a).

In this respect, the Court should consider (1) whether the violation was related to other illegal activities, (2) the availability of other penalties and the maximum penalties which could have been imposed, (3) the extent of the harm caused, and (4) the amount of the forfeiture relative to the gravity of the offense. *United States v. 3814 NW Thurman Street, Portland, Or., A Tract of Real Property,* 164 F.3d 1191, 1197-98 (9th Cir. 1999); *see also Vasudeva v. United States,* 214 F.3d 1155, 1161 (9th Cir. 2000) (examining the "the severity of the offense, the criminal fine that could have been imposed, and the harm caused by the defendant.").

DISCUSSION

A. Other Related Activities

The first factor for consideration is whether the misconduct at issue is related to any other illegal activities. *Thurman,* 164 F.3d at 1197. In this case, there is no indication that Mackby was involved in other illegal activity.

B. Other and Maximum Penalties Which Could Have Been Imposed

The Court next considers the availability of other penalties and the maximum penalties that could have been imposed. *See id.* The maximum penalties under the FCA, as applied to this case, are substantial. The FCA authorizes imposition of a civil penalty of up to $10,000 per claim as well as three times the actual damages sustained by the Government. 31 U.S.C. § 3929(a). Mackby caused 8,499 false claims to have been submitted, thereby exposing him to a maximum civil penalty of

$84,990,000.[5] In addition, based on the improper payment of $331,078.00 in federal funds, the maximum treble damage award the Court could have imposed was $993,234.00. *Id.* 31 U.S.C. § 3729(a). Thus, Mackby's maximum exposure is almost $86 million.

There is no dispute that the amount of the judgment – $729,454.92 – is within the range prescribed by statute, and as such, is presumptively constitutional. *United States v. 817 N.E. 29th Drive, Wilton Manors, Fla.*, 175 F.3d 1304, 1309 (11th Cir. 1999) ("if the value of forfeited property is within the range of fines prescribed by Congress, a strong presumption arises that the forfeiture is constitutional."). Significantly, the judgment imposed is but a fraction of what could have been imposed. The Government did not seek a penalty for each of the 8,499 false claims submitted by Mackby between 1992 and 1996. Rather, it requested the imposition of a penalty for only 111 claims, reflecting one claim per beneficiary per year that exceeded the PTIP payment limit. As to these 111 claims, the Government sought the minimum penalty of $5,000, rather than the statutory maximum of $10,000. Further, the Government limited its damage claim from $331,078 to $58,151.64. The latter figure reflected the difference between the amount that Medicare paid to the Asher Clinic and the amount which the clinic would have been entitled to receive if it were a qualified PTIP – which it was not.

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[5] Actual damages are not required for imposition of a civil penalty. *U.S. ex rel. Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir.1991).

The fact that the civil penalty and treble damage award requested by the Government and ultimately entered by the Court are far below the amounts which could have been imposed supports the conclusion that the judgment is not grossly disproportionate to the gravity of Mackby's conduct. The Ninth Circuit and other federal courts have consistently found that civil penalty awards in which the amount of the award is less than the statutory maximum do not run afoul of the Excessive Fines Clause. *E.g., Balice v. U.S. Dept. of Agric.,* 203 F.3d 684, 699 (9th Cir. 2000) (holding that a $225,500 fine did not violate the Eighth Amendment where the maximum fine was $528,000, notwithstanding the lack of monetary loss to the government); *Ghaith R. Pharaon v. Board of Governors of the Fed. Reserve Sys.,* 135 F.3d 148, 156 (D.C. Cir. 1998) (holding that a $37 million penalty did not violate the Excessive Fines Clause since "the penalty is proportional to his violation and well below the statutory maximum [of $111.5 million]"); *United States v. Emerson,* 107 F.3d 77, 79 (1st Cir. 1997) (holding that "a fine one-half the size of that permitted by the relevant statute, assessing $5,000 for each of [defendant's] thirty-seven admitted violations rather than the statutory maximum of $10,000 per violation . . . though substantial, is constitutionally permissible"); *United States v. Advance Tool Co.,* 902 F. Supp. 1011, 1018 (finding that an award of $365,000.00 as a civil penalty under the FCA did not violate the Eighth Amendment where maximum penalty was over $3.4 million, notwithstanding the Government's failure to prove any actual damages).

Mackby acknowledges that the combined maximum penalty of almost $86 million far exceeds the amount of the judgment actually imposed by the Court. Nonetheless,

he argues that the FCA does not authorize the Government to "unilaterally" determine the amount of the penalty and damages sought in a particular FCA case. Mackby also accuses the Government of abusing its "prosecutorial discretion" by attempting "to extort a large money settlement from Mr. Mackby. . . . " (Def.'s Reply at 15.) The import of these contentions is unclear. While a plaintiff in an FCA action may certainly request an amount certain in penalties and damages, the actual amount of the award is determined by the court, not the plaintiff. *Mackby* 261 F.3d at 830-31. Moreover, his hyperbole aside, Mackby presents no legal authority or evidence to support his arguments. The Court therefore finds that the amount of the judgment relative to Mackby's maximum exposure weighs in favor of the Government.

C. Extent of the Harm Caused

"In determining whether the forfeiture is grossly disproportionate given the gravity of the offense, the court should consider the extent of the harm caused." *Thurman,* 164 F.3d at 1197. Relevant to this consideration is the government's actual loss. *Id.* Under the FCA, "[o]rdinarily the measure of the government's damages would be the amount that it paid out by reason of the false statements over and above what it would have paid if the claims had been truthful." *United States v. Woodbury,* 359 F.2d 370, 379 (9th Cir. 1966). Here, the Government paid a total of $331,078 in Medicare claims as a direct result of Mackby's submission of false claims, i.e., claims improperly bearing his father's PIN. Had the claims been truthful, Mackby would have been entitled to nothing, since he was neither providing nor supervising the provision of physical therapy services. However, as noted, the Government is not

claiming the full amount of this loss. Instead, the Government voluntarily restricted its claimed loss to $58,151.64, which represents the amounts paid between 1992 and July 1996 which exceeded the annual payment limit per beneficiary for PTIPs.

In response, Mackby contends that the Government incurred no loss because he was entitled to reimbursement for physical therapy services below the annual cap on payments. (Mackby Reply at 3-4.) Specifically, he contends that Medicare regulations entitled the Asher Clinic to submit Medicare Part B claims because the clinic was a "supplier" rather than a "provider" of health care services. (*Id.*) However, this argument has been considered and rejected by this Court as well as the Ninth Circuit. As such, Mackby is barred from rearguing the merits of this claim. *See Vizcaino v. U.S. Dist. Court for Western Dist. of Wash.*, 173 F.3d 713, 719 (9th Cir. 1999) (noting that upon remand from an appellate court, the district court must proceed in accordance with the mandate and may not allow litigants to relitigate issues which they have previously had an opportunity to address).

Next, Mackby asserts that the Government suffered no harm because all of the patients for whom he submitted false Medicare claims actually received physical therapy services, and that "Medicare would have paid the same for services that it actually paid to the Asher Clinic if Asher Clinic had submitted 'true claims.'" (Def.'s Opening Brief at 9.) Indeed, Mackby asserts that he actually saved the Government money: "if the patients had gone to another rehabilitation center or some other institutional provider of physical therapy services, rates greater than actually paid to the Asher Clinic would have been paid because Medicare pays the reasonable costs of physical therapy

services furnished at an institutional provider without imposing the 'artificial' limit [resulting from the cap on Medicare payments]." (*Id.*) According to Mackby, since the Government allegedly suffered no loss, the fine imposed is excessively punitive.

Mackby's argument misses the mark. The measure of the Government's damages is not a function of the value of the underlying services provided nor the amounts that it would have legitimately paid to another authorized provider of those services. *See U.S. ex rel. Hopper v. Anton,* amount 91 F.3d 1261, 1266 (9th Cir. 1996) ("[T]he [FCA] attaches liability, not to underlying fraudulent activity, but to the 'claim for payment.'"). Instead, the amount the Government paid in response to the false claims is an appropriate measure of damages. *Cf., United States v. TDC Management Corp.,* 288 F.3d 421, 428 (D.C. Cir. 2002) (affirming district court's use of a "but for" measure of damages in an FCA action, based on the amount the government would have paid had the claim been truthful). The Court further notes that Mackby's "no harm no foul" argument was considered and rejected in *Peterson v. Weinberger,* 508 F.2d 45 (5th Cir. 1975), a decision cited with approval by the Ninth Circuit in this case. *See Mackby,* 261 F.3d at 826.

In *Peterson,* a non-physician owner of a physical therapy company called Zodiac Enterprises used the provider number and signature of his physician-brother, Dr. Peterson, to bill Medicare. Like Mackby, Dr. Peterson did not provide any of the physical therapy services at issue. The defendants argued that there was no violation of the FCA since "the patients receiving . . . services were entitled to them under Medicare, there was no financial loss to the Government, and the monies paid by the

Government were therefore a liability which the Government was statutorily obligated to pay." *Id.* at 52. The Fifth Circuit flatly rejected this argument:

> The services were rendered by Zodiac who was not a certified provider. It could not have been paid, had it submitted a bill to Blue Cross. Furthermore, it is abundantly clear that Dr. Peterson was not the medical director of Zodiac, nor had he any supervision over the physical therapist who actually rendered the services. *In short, the services billed were plainly not "covered" services, and the Government thus paid on the basis of the false claims presented.*

Id. (emphasis added). Consequently, the Fifth Circuit upheld the judgment in favor of the government, which consisted of an award double the amount of the sums paid by Medicare on the false claims, plus penalties. *Id.* at 49, 55.[6]

As in *Peterson,* Mackby, a non-physician, was not eligible to bill Medicare, so he used the identification of a qualified physician-relative to submit those claims. His contention that the Government did not suffer any damages because Medicare would have paid for these services had the patients gone elsewhere for treatment completely misses the point. *The Asher Clinic was not entitled to receive funds from Medicare;* the only reason the clinic received any monies was through the use of a PIN belonging to a physician who was qualified to submit such a

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[6] The FCA was amended in 1986 to permit the imposition of treble damages.

claim. Thus, the Court agrees with the Government that it suffered direct damages in the amount of $331,078.

In an attempt to distinguish *Peterson,* Mackby argues subsequent amendments to Medicare in 1972 render that opinion inapposite. (Def.'s Reply at 5.) Specifically, the regulations then in effect in *Peterson* specified that Medicare would only reimburse claims for physical therapy if the services were performed by a physician or at the physician's direction. Mackby contends that the basis of the false claim charge in *Peterson* was the fact that a physician certified to Medicare that he performed services which he, in fact, did not perform or supervise. (*Id.* at 6-7.) However, the regulations have since been amended such that a physical therapist may now perform those services. Thus, Mackby emphasizes that unlike *Peterson,* all of the claims he caused to be submitted were actually covered by Medicare, in contrast to the claims in *Peterson,* which were not. (*Id.*)

In essence, Mackby's argument is nothing more than a transparent attack on this Court's finding of liability which was affirmed and specifically addressed on appeal. In its opinion, the appellate panel stated that:

> Mackby argues that the falsity of the claims submitted by Asher Clinic depends "solely upon the technical interpretation of the instructions for the claims" *because the claims accurately describe physical therapy services that were actually rendered.* However, the fact that physical therapy services were actually rendered does not negate Asher Clinic's false representation that Dr. Mackby performed the services described on the claim forms or that those services were rendered incident to Dr. Mackby's supervision. It is the

> representation of Dr. Mackby's involvement that is "false," and that falsity is sufficient to satisfy the first element of an FCA claim. *See Peterson,* 508 F.2d at 52 (a Medicare claim may be false even if services were provided).

Mackby, 261 F.3d at 827. Thus, whether or not the claims could have been eligible for reimbursement is irrelevant. Under the regulations applicable to Mackby, physical therapy services could only be reimbursed by Medicare Part B if rendered by a physician, incident to a physician's services, or by a qualified PTIP. As in *Peterson,* since Mackby was not qualified to submit claims to Medicare, he used false information (i.e., his father's PIN) to make it appear that the services in question were eligible for Part B reimbursement. The Court therefore finds no merit to Mackby's attempt to distinguish *Peterson* nor with respect to his assertion that the Government sustained no harm as a result of his violation of the FCA.

D. Gravity of the Offense Relative to the Amount of the Judgment

The fourth and final *Thurman* factor counsels the Court to consider the amount of the forfeiture relative to the gravity of the offense. 175 F.3d at 1309. In an attempt to minimize the seriousness of his misdeeds, Mackby characterizes his conduct as a "mere billing *technicality*" or "alleged billing *discrepancy*" which was limited to a "single 'misrepresentation'" involving "*arcane* Medicare billing rules. . . . " (Def.'s Opening Brief at 1, 6, 13 (emphasis added).) He also repeats his assertion that the Government suffered no monetary loss since the Government would have paid another clinic for the physical therapy services in lieu of the Asher Clinic. (Def.'s Reply Brief at

8.) Given the allegedly minor nature of his transgressions, Mackby argues that "any penalty in excess of $5,000.00 in this case would constitute an excessive fine." (Def.'s Opening Brief at 12-13.) The Court disagrees.

The prevalent theme of Mackby's briefs is his belief that he should never have been accused of any wrongdoing by the Government and that he should not have been found liable under the FCA. (*Id.* at 9, 11.)[7] Mackby goes so far as to request that this Court "consider, as a threshold matter, whether, under the circumstances of this case, *this action should have been the subject of an action under the False Claims Act in the first place.*" (*Id.* at 6 (emphasis added).) In other words, Mackby believes that the judgment is excessive because the Government should not have pursued this action against him. This contention is meritless. The matter of Mackby's culpability has been finally resolved by the Ninth Circuit. *Mackby,* 261 F.3d at 829. Consequently, the "law of the case" doctrine forecloses reconsideration of Mackby's liability. *See Vizcaino,* 173 F.3d at 719.

Moreover, despite Mackby's protestations to the contrary, his submission of false claims to the United States is a *serious* matter. *See In re Commonwealth Cos., Inc.,* 913 F.2d 518, 526 (8th Cir. 1990) ("In view of the case law identifying the purposes of the FCA and the statute's legislative history, we conclude that civil actions by the government to enforce the FCA serve to inflict the 'sting of

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[7] This fact is underscored by Mackby's consistent presentation of terms such as "offense," "violation," "misrepresentation" and "wrongdoing" in quotation marks, as if he has done nothing wrong and is simply being victimized by the Government. (*Id.* at 1, 2, 10, 13.)

punishment' on wrongdoers and, more importantly, deter fraud against the government, *which Congress has recognized as a severe, pervasive, and expanding national problem.*") (emphasis added). It is also important to note that Mackby's actions have undermined the public's confidence in the Government's ability to manage its programs. *See U.S. ex rel. Rosales v. San Francisco Hous. Authority,* 173 F. Supp. 2d 987, 1019 (N.D. Cal. 2001) (noting that the government's harm in an FCA case is not "easily measurable in dollars" since "fraud erodes public confidence in the government's ability to efficiently and effectively manage its programs.") (quoting S. Rep. No. 99-345, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S.Code Cong. & Admin. News 5268). Based on the record presented, it is clear that Mackby engaged in a course of deceit which involved the submission of thousands of false claims over the course of four years. As the Ninth Circuit recognized in its opinion, Mackby acted "in reckless disregard or deliberate ignorance" of Medicare requirements and falsely represented himself to be a physician-run practice in order to avoid the Medicare payment cap. *Mackby,* 261 F.3d at 828-29.

The Court further finds that the full amount of the judgment previously imposed by the Court is necessary and appropriate for purposes of deterrence. *Id.* at 831 (directing this Court consider "whether a fine as large as that imposed . . . is required to achieve the desired deterrence"). Mackby claims that a minimal fine is sufficient for purposes of deterrence since he is no longer in the health care business, has not been gainfully employed since the inception of this action, and because "[t]he consequences of his action in this case continue to haunt him independent of the amount of the money judgment." (Def.'s Reply at

16.) Aside from the paucity of evidence to support these assertions, Mackby's argument rings hollow given his steadfast denial of any wrongdoing, notwithstanding this Court's and the Ninth Circuit's determination to the contrary. Mackby's unwillingness to assume responsibility for and accept the consequences of his actions underscores the need and propriety of the instant judgment. *Cf., Brown & Williamson Tobacco Corp. v. Jacobson,* 827 F.2d 1119, 1142 (7th Cir. 1987) ("because the purpose of punitive damages is deterrence, the jury was entitled to consider evidence of post-verdict recalcitrance in determining the punitive damages award."). Mackby's assertion that a $5,000 fine is sufficient "as an adequate deterrent" is absurd given the seriousness of this matter and his attitude.

E. Request for an Offset

Finally, Mackby contends that he is entitled to an offset in the amount of $100,000 for services which the Asher Clinic provided to Medicare patients in 1996. (Def.'s Opening Brief at 13-14.) After Medicare uncovered and contacted the Asher Clinic regarding the improper billings under Medicare Part B, Mackby expended considerable effort to have the clinic meet the conditions of Medicare eligibility for a rehabilitation agency so that it would no longer be required to bill under Medicare Part B. (FFCL ¶ 20.) On June 4, 1996, Mackby submitted a requested to have the Asher Clinic certified as a rehabilitation clinic. (*Id.*) Medicare granted the request on September 13, 1996. (*Id.*) Thus, Mackby maintains that he is entitled to an offset for services rendered to Medicare patients during the time period after which he ceased using his father's

PIN and up to the date of the clinic's certification as a rehabilitation agency. (Def.'s Opening Brief at 13-14.)

The Court finds that Mackby is not entitled to any offset. As the Government correctly points out, Mackby is, in effect, seeking reimbursement for services rendered to Medicare patients during a time-period in which he had no right to such monies. Mackby counters that the clinic is entitled to these funds since from 1992 until the clinic was certified as a rehabilitation agency in 1996 it was a "supplier" of health care services. However, as discussed above, this contention is not properly before the Court.[8] In any event, Mackby's claim for reimbursement is beyond the scope of this action. To the extent he is seeking an offset based on claims which were never submitted to Medicare, Mackby must first submit those claims to Medicare and exhaust his administrative remedies. *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 12-13 (2000). However, there is no evidence that he has exhausted such remedies.

CONCLUSION

Mackby's actions amount to much more than a "billing technicality" – they reflect a serious, ongoing, and deliberate course of conduct designed to obtain Medicare payments for which he was not qualified. Mackby's continued refusal to assume responsibility for his misconduct underscores the need for a sizeable judgment to deter him and others from engaging in similar conduct. In sum, the

[8] In addition, none of the cases cited by Mackby involve the FCA, and hence, are inapposite.

Court finds that neither the civil penalty nor the treble damage award, either individually or collectively, is grossly disproportionate to the gravity of Mackby's violation of the FCA. The Court therefore concludes that the judgment previously entered in this action does not violate the Excessive Fines Clause of the Eighth Amendment. Accordingly,

IT IS HEREBY ORDERED THAT the judgment against Mackby in the amount of $729,454.92 previously entered by this Court on March 10, 1999 shall remain as previously entered. The Clerk shall close the file and terminate any pending matters.

IT IS SO ORDERED.

Dated: September 3, 2002

/s/ Saundra B Armstrong
SAUNDRA BROWN ARMSTRONG
United States District Judge

ROBERT S. MUELLER, III
United States Attorney
GAIL KILLEFER (SBN 157248)
Chief, Civil Division
Assistant United States Attorney

450 Golden Gate Avenue, Box 36055
San Francisco, California 94102
Telephone: 415/436-6996

Attorneys for the United States

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND BRANCH

UNITED STATES OF AMERICA, Plaintiff, v. PETER MACKBY, Defendant.	No. C-98-1310 SBA PLAINTIFF'S AMENDED FINDINGS OF FACT AND CONCLUSIONS OF LAW (Filed Mar. 10, 1999) Trial: February 18, 19, 22, 1999

The United States Brings this action against Peer Mackby ("Mackby"), alleging violations of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, and various common law theories in connection with claims for physical therapy services which the defendant caused Asher Clinic to submit to Medicare for payment. This matter was tried to the Court on February 18, 19, and 22, 1999.

FINDINGS OF FACT

1. Michael Leary, a licensed physical therapist, and defendant Peter Mackby entered into a partnership in 1982 for purposes of owning and operating Asher clinic in Larkspur, California. During the partnership, Asher Clinic billed Medicare using Leary's provider number. Medicare checks were sent to Asher Clinic made out to Michael Leary, RPT.

2. A dispute eventually arose between defendant Peter Mackby and Michael Leary. Mackby filed an action against Leary in Marin Superior Court, and in June 1988, settled the action by purchasing Leary's interest in the Asher clinic on June 20, 1988 for $320,000. Defendant became, and remained throughout the relevant time period, the Managing Director of Asher Clinic.

3. The Articles of Incorporation for MI Enterprises, were filed with the California Secretary of State on June 14, 1988. *Exhibit 22*. The Bylaws for M1 Enterprises were dated November 3, 1988. *Exhibit 24*. The preamble of the Bylaws state that the Bylaws were "drafted with the intention that M1 Enterprises, Inc. is a one man corporation, whose sole shareholder is Peter J. Mackby." *Id.*, p.1. At the First Meeting of the sole Director of M1 Enterprises, Inc., Peter Mackby was elected President, Chief Financial Officer and Treasurer, and Secretary. *See Minutes, Exhibit 25, p. 3.* Defendant Peter Mackby remained President and sole shareholder of M1 Enterprises throughout the relevant time period.

4. On November 3, 1988, M1 Enterprises purchased Asher Clinic. *See Exhibit 77.*

5. During the relevant time period, the HCFA 1500 claim was the standard form for billing all insurances for outpatient physician and physical therapy services. *Testimony of Patricia Sinnott; Exhibit 35.* Box 24k of the form is used by the biller to describe the provider identification for the individual providing or supplying the services. The Medicare instructions for Box 24k [*Exhibit 39*, p. 5; *Exhibit 42*, p. 18; *Exhibit 44*, p. 21] require that the "carrier assigned 9-digit PIN for the performing physician or supplier" be inserted. Box 33 is used to identify the supplier (physician or physical therapist) who holds the agreement with any certain insurance payor. The Medicare instructions require that the "carrier issued 9-digit PIN for the billing entity" be inserted in Box 33, with the name, address and telephone number of the physician or supplier who is billing. *See Exhibit 39, p. 6; Exhibit 42*, p. 19-20; *Exhibit 44*, p. 23.

6. Mackby caused Asher Clinic to bill Medicare with the provider number of his father, M. Judson Mackby, N.D. *Testimony of Peter Mackby, February 18, 1999.* On June 22, 1988, he told Jon Larson of Medicom, the billing service for Asher Clinic, to substitute Dr. Mackby's provider number for the then-current provider number registered through Mike Leary. *Id. See also* Exhibit 9, pp. 3-4: no. 17; *Testimony of Jon Larson, February 18, 1999.*

7. Mackby also told Maridy Barnett, the office manager for Asher Clinic, to use his father's medical license number in billing third party payors, including Medicare. *Mackby Testimony, February 18, 1999.* Maridy Barnett also testified that Mackby gave her his father's provider number to substitute for that of Michael Leary. *See Testimony of Maridy Barnett, February 19, 1999.*

8. Because Mackby instructed Jon Larson of Medicom, the billing company for Asher Clinic, and Maridy Barnett, the office manager, to substitute his father's provider number for Leary's provider number for insurance billing, thereafter Medicare received claims for physical therapy services from Asher Clinic in which Dr. Mackby's Medicare Provider Identification Number ("PIN") was placed in Boxes 24k and 33. This indicated that the physical services provided were performed by Dr. Mackby or incident to his service, which was false.

9. The evidence at trial established that Medicare believed that Dr. Mackby was the rendering provider at Asher Clinic. The Medicare checks [*see* Exhibit 60] were made payable to "M. Judson Mackby, M.D." and sent to the Asher Clinic address. Asher Clinic used a rubber endorsement stamp containing Dr. Mackby's name to endorse and deposit Medicare payments. The Explanation of Medicare Benefits ("EOMBs") [*see* Exhibit 56] which were sent to Asher Clinic and to the Medicare beneficiaries identified Dr. Mackby as the rendering provider of the services. When the EOMB was sent to Asher Clinic, it was addressed to "M. Judson Mackby, N.D." at the Asher Clinic address. *Id.* All Medicare's audit inquires were addressed to Dr. Mackby at the Asher Clinic address. *See e.g.* Exhibits 47, 48, 50, 52. The Medicare Bulletins were also addressed to Dr. Mackby at the Asher Clinic address. *Testimony of Marida Barnett, February 19, 1999.* Finally, the testimony of Gaye Eaton established that because Dr. Mackby's PIN was placed in Boxes 24k and 33, Medicare believed that Dr. Mackby was providing the services for which Asher Clinic was billing or, at the very least, that such services were rendered "incident to" his supervision. *Testimony of Gaye Eaton, February 19, 1999.*

10. Dr. Mackby was not, in fact, the rendering provider. He lived in Connecticut from 1986 to 1994, when he moved to Kentucky. *Exhibit 80, Videotape Deposition of M. Judson Mackby, M.D; Exhibit 38, Declaration of M. Judson Mackby, M.D., ¶¶ 1,2,4 (May 14, 1998).* He never provided medical services at or for Asher Clinic, and never referred any patients to Asher Clinic. He was never involved with the care or treatment of patients at Asher Clinic.

11. Mackby's assertion that he relied on the advice of Cecily Waterman, a partner at the San Francisco law firm of Brobeck, Phleger & Harrison ("Brobeck"), is not credible. Waterman denied that she had given Mackby any advice on billing issues, and that the issue was simply never discussed between them. Gabrielle Wirth, another Brobeck lawyer who worked with Ms. Waterman, also denied that Waterman gave such advice or that "billing issues" were ever raised by or researched for Mackby.

12. Moreover, Mackby's testimony concerning the "meeting" he had with his father, Waterman, and Wirth in June 1988 is not credible. The three other participants of the meeting denied that the issue of the use of Dr. Mackby's medical license number or PIN was ever discussed. Waterman and Wirth recalled meeting Dr. Mackby briefly in a social setting at their law firm. The fact that neither lawyer included such a meeting in their billing records for the month of June indicated that the meeting with Dr. Mackby was brief, not significant, and more social than substantive. Dr. Mackby did not know that his PIN was being used for billing Medicare for physical therapy services provided by Asher Clinic. *Exhibit 80, Videotape Deposition of M. Judson Mackby, M.D.; see also Exhibit 38, Declaration of M. Judson Mackby, M.D., ¶¶ 2, 4, (May 14, 1988).*

13. Even if Waterman had given Mackby advice in the summer of 1988 to place his father on a corporate board to enable Asher Clinic to bill Medicare, Mackby did not follow the advice until October 26, 1989, when his father was elected to the Board of M-1 Enterprises. *See Exhibit 26, Minutes of Annual Meeting, October 26, 1989.* As of the November 3, 1988, First Meeting of the Shareholders of M-1 Enterprises, Peter Mackby was elected President and Secretary of the corporation. *See Exhibit 25, ¶ 14.* The fact that Mackby substantially delayed in implementing the purported advice he now relies upon challenges Mackby's credibility.

14. Finally, Mackby received a letter from his then-lawyer, Leonard Rifkind, in November 1989 with Instructions for Medicare Eligibility, which Asher clinic clearly did not meet. *See Exhibit 62, Rifkind Correspondence, pp.* 5-6. Despite these instructions, Mackby asserts he believed that it was appropriate for Asher Clinic to bill Medicare with his father's PIN based upon Waterman's advice. *Mackby Testimony, February 22, 1999.* Yet by this time, Mackby had counterclaimed against Waterman in a lawsuit in Marin County, alleging professional negligence. At trial, he testified that a letter he received from Ms. Waterman, dated August 3, 1988, explaining the reasons for his withdrawal from his partnership with Michael Leary was entirely incorrect. *See* Exhibit 54, pages 2-3, *Mackby Testimony, February 18, 1999.* That Mackby never questioned Waterman's purported advice on the billing issue defies credibility in light of his testimony that he lost confidence in her shortly after he took control of Asher Clinic in 1988, and in light of the fact that he was presented in 1989 with Instructions for Medicare Eligibility which Asher Clinic clearly did not meet.

15. Similarly, Mackby's purported reliance on Maridy Barnett to ensure that Asher Clinic complied with Medicare rules and regulations is not credible. Barnett had no training in Medicare rules and regulations, and did not represent to Mackby that she was knowledgeable in this area. *Testimony of Marida Barnett, February 19, 1989.* She generally followed Mackby's instruction, and would not challenge him. As managing Director of the Asher Clinic, Mackby was "responsible for not only day-to-day operations, but also long-term planning, lease and buildout negotiations personnel, legal and accounting issues." *See Exhibit 67, p. 6; Testimony of Peter Mackby, February 18, 1999.* Mackby knew every facet of Asher Cinic's business and was a hands-on manager and a shrewd businessman, with an interest in the bottomline. *Testimony of Gary Galloway, February 22, 1999.*

16. Barnett wrote a letter dated June 24, 1988, requesting the "necessary applications needed in order for this clinic to obtain a Medicare Provider Identification Number for billing." *Letter, Exhibit 10.* There was no attempt, however, to follow-up on this request until 1996. Barnett later wrote to Medicare on June 28, 1991, requesting that the name and provider number of a physical therapist be substituted for Dr. Mackby's name and provider number. *Letter, Exhibit 14.* Blue Shield's response, dated July 11, 1991, directed to the Blue Shield private provider number, shows a misunderstanding by Medicare as to what Ms. Barnett requested. *Letter, Exhibit 17.* Barnett believed that Medicare did not understand what she requested in her June 1991 letter. She discussed the letter with Mackby, but was not told to follow up.

17. Barnett was uncomfortable with the fact that Asher Clinic was using Dr. Mackby's PIN, and that Medicare

correspondence and checks were always addressed to Dr. Mackby at the Asher Clinic address. When she or other staff confronted Mackby with these concerns four or five times at staff meetings, he did not respond – until 1996. On one occasion when Barnett asked Mackby as to why Medicare was not imposing a limitation on expenses once Dr. Mackby's PIN was used, Mackby responded: "why open a can of worms?"

18. On cross-examination, Mackby testified that the witnesses – his father, Waterman, Wirth, Larson, and Barnett – each lied under oath, and that only he was telling the truth. *Mackby Testimony, February 22, 1999.* Yet Mackby was not credible: he ignored the concerns expressed by his employees and clients about the use of his father's number of purposes of billing Medicare, and continued to bill in a fashion not permitted by law.

19. The evidence at trial established Mackby's motivation for using his father's PIN was to allow "a seamless transition in the treatment of Medicare patients at Asher Clinic" after Mackby bought out Michael Leary's partnership interest. *See Letter from Leonard Rifkind to Dr. Mackby, Exhibit 53 p. 1. See also Exhibit 49, Letter to Gaye Eaton from Peter Mackby, May 10, 1996, p. 2.*

20. To become certified as a rehabilitation agency, Asher clinic was required to develop an institutional or administrative structure and additional services. *See Testimony of Patricia Sinnott.* These requirements were both burdensome and costly. *Id.* Mackby avoided these burdens by substituting his father's PIN for that of Michael Leary. In March 1996, however, Medicare contacted Dr. Mackby at the Asher Clinic address and requested medical records for purposes of an audit. *See Exhibit 47,*

Letter of March 28, 1996. Shortly thereafter, Mackby expended considerable effort to have Asher Clinic meets the conditions of Medicare eligibility as a rehabilitation agency. *Testimony of Maridy Barnett.* Mackby applied for Asher Clinic's certification as a Medicare rehabilitation agency on June 4, 1996 (*Exhibit 70*); the clinic was surveyed on July 10, 1996 (*per stipulation of the parties*); and Medicare accepted the clinic as a rehabilitation agency on September 13, 1996 (*Exhibit 68*). Thereafter, Asher Clinic no longer billed Medicare Part B.

21. M-1 Enterprises sold Asher Clinic to Regency Health Systems in May 1997 for 1.7 million.

22. The parties stipulated to the following concerning claims submitted, and paid, during the relevant time frame:

(A) In 1992, Asher Clinic submitted to Medicare a total of 956 claims for physical therapy services, for which Medicare paid $31,735 to Asher Clinic through checks made payable to M. Judson Mackby, M.D. Of these claims, Asher Clinic submitted 155 claims exceeding $750 for physical therapy services for 13 different beneficiaries, totaling $6,190.65.

(B) In 1993, Asher Clinic submitted to Medicare a total of 1,387 claims for physical therapy services, for which Medicare paid $52,608 to Asher Clinic through checks made payable to M. Judson Mackby, M.D. Of these claims, Asher Clinic submitted 281 claims exceeding $750 for physical therapy services to 19 different beneficiaries, totaling $10,416.88.

(C) In 1994, Asher Clinic submitted to Medicare a total of 2,258 claims for physical therapy services, for

which Medicare paid $93,695 to Asher Clinic through checks made payable to M. Judson Mackby, M.D. Of these claims, Asher Clinic submitted 442 claims exceeding $900 for physical therapy services for 32 different beneficiaries, totaling $16,379.75.

(D) In 1995, Asher Clinic submitted to Medicare a total of 2,326 claims for physical therapy services, for which Medicare paid $96,482 to Asher Clinic through checks made payable to M. Judson Mackby, M.D. Of these claims, Asher Clinic submitted 426 claims exceeding $900 for physical therapy services for 33 different beneficiaries, totaling $18,713.90.

(E) In 1996, Asher Clinic submitted to Medicare a total of 1,572 claims for physical therapy services, for which Medicare paid $56,558 to Asher Clinic through checks made payable to M. Judson Mackby, M.D. Of these claims, Asher Clinic submitted 155 claims exceeding $900 for physical therapy services for 14 different beneficiaries, totaling $6,450.46.

CONCLUSION OF LAW

1. The Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1345, 31 U.S.C. § 3730(a) and its general equitable jurisdiction. Venue is proper in this district under 28 U.S.C. § 1391 and 31 U.S.C. § 3732(a).

2. The U.S. Department of Health and Human Services ("HHS"), through its component agency, the Health Care Financing Administration ("HCFA"), administers the national Medicare Program. 42 U.S.C. § 1395u. The Medicare Program, which is set forth in Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc, consists of

two parts. Part A, which is not at issue here, provides hospital insurance benefits to the elderly and disabled. 42 U.S.C. § 1395c-1395i-2. Part B is a federally subsidized, voluntary insurance program that pays a portion (typically 80%) of the cost of certain medical and other health services, including physician and laboratory services, not covered by the Part A program. 42 U.S.C. § 1395j-1395x(s). Reimbursement for Medicare claims is made by the United States through HCFA. HCFA, in turn, contracts with private insurance carriers to administer and pay Part B claims from the Medicare Trust Fund. 42 U.S.C. § 1395u. In this capacity, the carriers act on behalf of HCFA. 42 C.F.R. § 421.5(b). The Medicare carrier involved in this matter was Blue Shield of California.

3. Medicare Part B pays for physical therapy services under only two circumstances: (1) physical therapists in independent practice ("PTIP"); and (2) physicians, who may provide physical therapy services personally, or with appropriately licensed and qualified professional employees when the services are "incident to" that physician's services. *Testimony of Gaye Eaton, February 19, 1999.* PTIPs must meet specific requirements for participation. *See* CFR CH.IV subpart D, §§ 486.150-163. Physical therapy services provided by a physician must also meet certain requirements. *See e.g. Exhibit 40, Medicare Bulletin*, No. 90-3, pp. 19-22 (May 1990); *Exhibit 41, Medicare Bulletin*, No. 91-3, pp. 5-7 (August 1991); *Exhibit 42, Medicare Bulletin*, No. 93-2, pp. 22-25 (March 1993). Under each circumstance, however, the PTIP and the physician must have in effect an agreement to participate in Medicare. Medicare limits the amount that a PTIP can bill on behalf of any one Medicare beneficiary in any calendar year. 42 C.F.R. § 410.60(c)(2).

4. Medicare limits the amount that a PTIP can bill on behalf of any one Medicare beneficiary in any calendar year. 42 C.F.R. § 410.60(c)(2). From 1992 through 1993, the limit was $750 per year; from 1994 through 1996, $900 per year. There is no similar limit on physical therapy services furnished by or under the supervision of a physician or incident to a physician's service.

5. To establish a claim under the False Claims Act (FCA), 31 U.S.C. § 3729(a)(1), the United States must prove three elements: (1) that the defendant presented, or caused another person to present, a "claim" for payment or approval to the United States; (2) the claim must be "false or fraudulent"; and (3) the defendant must have acted knowing that the claim is false. *See generally United States ex rel. Hopper v. Anton,* 91 F.3d 1261, 1266 (9th Cir. 1996); *United States ex rel. Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991).

6. A "claim" under the FCA is a demand for the payment of government money or the transfer of government property. It is well established that a claim for Medicare payment is a "claim" for purposes of the False Claims Act. *Peterson v. Weinberger*, 508 F.2d 45, 52 (5th Cir. 1975) (a claim for Medicare payment is a "claim" for purposes of the act). The claims at issue here as the HCFA 1500 claims which Asher Clinic submitted to Medicare Part b for physical therapy services.

7. Generally, the "phrase known to be false" means, essentially, "a lie," not merely what is scientifically untrue. *See Wang v. FMC*, 975 F.2d 1412, 1421 (9th Cir. 1992). The "lie" on the HCFA 1500 forms that Mackby caused Asher Clinic to submit to Medicare appears in boxes 24k and 33 as 000G11460, which is Dr. Mackby's

PIN. This indicated to Medicare that the physical therapy provided were performed by Dr. Mackby or "incident to" his services, which was false.

8. Between 1988, after Michael Leary's departure, and 1996, when Asher Clinic became certified as a Medicare rehabilitation agency, Mackby caused Asher Clinic to present false claims for payment to the Medicare carrier Blue Shield of California.

9. Liability under the FCA may be imposed either where there is actual knowledge of the falsity of the information submitted, or requires at least "deliberate ignorance" or "reckless disregard" of the truth or falsity of the information presented to the government. 31 U.S.C. § 3729(b); *United States ex rel. Hagood v. Sonoma County Water Agency,* 929 F.2d 1416, 1421 (9th Cir. 1991). Proof of specific intent to defraud the government is not required. *Id.* The requisite intent is the knowing presentation of what is known to be false. *See generally United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996); *United States ex rel. Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991).

10. Those who deal with the Government are expected to know the law: "[p]rotection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law." *Heckler v. Community Health Services*, 467 U.S. 51, 63 (1984). Participants in the Medicare program have a duty to familiarize themselves with the legal requirements for cost reimbursement. *Id.* at 64. As the Managing Director of Asher Clinic, and sole shareholder of the corporation which owned the Clinic, defendant had a duty to familiarize himself with the Medicare rules and guidelines regarding

participation in the Medicare program. *See United States v. Yvon Nazon, Md.*, 940 F.2d 255, 259-60 (7th Cir. 1991) (providers participating in Medicare program cannot escape criminal liability for false billing practices by claiming ignorance of Medicare requirements); *United States v. Cooperative Grain & Supply Co.*, 476 F.2d 47, 55 (8th Cir. 1973) (applicant seeking "public funds has a duty to read the regulations or be otherwise informed of the basic requirements of eligibility").

11. Under the FCA, knowledge can be proven in those instances where a defendant has "buried his head in the sand" or "failed to make any inquiry which would have revealed the false claims." *United States v. Entin*, 750 F.Supp. 512 (S.D.Fla. 1990) (citing the legislative history of the False Claims Act); *see also* S.Rep. No. 345, 99th Cong., 2d Sess. 1, 15 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266 (describing congressional intent to make actionable under the False Claims Act "the 'ostrich-like' refusal to learn of information which an individual, in the exercise of prudent judgment, had reason to know"). *See also United States v. Krizek*, 859 F. Supp. 5, 13 (D.D.C. 1994) (violation of FCA where defendant was reckless in submitting bills to Medicare that contained factual representations "with little, if any, factual basis," which the court inferred from the circumstances of her actions).

12. Plaintiff has met its burden of proving that defendant knowingly caused false claims to be submitted to Medicare between 1992 and 1996. An individual may be held liable under the FCA for his own conduct and that of the employees he supervised. *See United States v. Lorenzo*, 768 F. Supp. 1127 (E.D. Pa. 1991).

13. The FCA provides that any person who violates its provisions is liable to the United States for a civil penalty of not less that $5,000 and not more than $10,000 for each false claim or statement submitted, plus three times the amount of damages which the government sustains because of the act of that person. 31 U.S.C. § 3729(a). No damages need be shown in order to recover the penalty mandated by the FCA. *United States ex rel. Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991).

14. Here, the United States is seeking treble damages for only the 1459 claims that Asher Clinic submitted to Medicare between 1992 and July 1996 which exceeded Medicare's annual payment limit per beneficiary for PTIPs, totaling $58,151.64. Treble damages are, therefore, awarded in the amount of $174,454.92.

15. The United States is also seeking the minimum penalty under the FCA of $5,000 for only one claim, submitted by Asher Clinic per beneficiary each year, that exceeded Medicare's annual payment limit for PTIPs, *ie*, 111 claims. Accordingly, the United States is awarded penalties in the amount of $550,000.

16. As the Court finds the defendant liable under the FCA, the Court need not reach plaintiff's common law claims.

17. Any finding of fact or conclusion of law stated herein which may be considered to be the other is deemed to be such.

18. Accordingly, judgment in the amount of $729,454.92 will be entered in favor of the United States.

Dated: 3-8-99

/s/ Saundra B. Armstrong
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. PETER MACKBY, Defendant.	No. C 98-1310 SBA JUDGMENT (Filed Mar. 10, 1999)

In accordance with the Court's March 8, 1999 Findings of Fact and Conclusions of Law deciding this matter in favor of plaintiff.

JUDGMENT IS HEREBY ENTERED in favor of the plaintiff United States of America in the amount of $729,454.92.

IT IS SO ORDERED.

DATED: March 9, 1999

/s/ Saundra Brown Armstrong
SAUNDRA BROWN ARMSTRONG
United States District Judge

Entered on Civil Docket 3/15/99

Plaintiff's Counsel are directed to serve this order upon all other parties in this action

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. PETER MACKBY, Defendant-Appellant.	No. 02-16778 D.C. No. CV-98-01310-SBA ORDER (Filed Sep. 12, 2003)

Before: HAWKINS and W. FLETCHER, Circuit Judges, and KING, * Senior District Judge.

The panel has voted to deny the petition for rehearing. Judges Hawkins and W. Fletcher have voted to deny the petition for rehearing en banc; and Judge King so recommends.

The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on whether to rehear the matter en banc.

Fed. R. App. P. 35.

The petition for rehearing and the petition for rehearing en banc, filed August 21, 2003, are DENIED.

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* The Honorable Samuel P. King, Senior District Judge for Hawaii, sitting by designation.

The Applicable Medicare Statutes And Rules

1. 42 U.S.C. Section 1395x(p) [1992]

The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient –

. . .

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary.

2. 42 C.F.R. Section 400.202 [1996]

As used in connection with the Medicare program, unless the context indicates otherwise –

. . .

Medicare Part A means the hospital insurance program authorized under Part A of Title XVIII of the Act.

Medicare Part B means the supplementary medical insurance program ["SMI"] authorized under Part B of Title XVIII of the Act.

. . .

Provider means a hospital, an RPCH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy, or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

. . .

Supplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

3. 42 C.F.R. Section 410.60 [1996] (superseded)

(a) *Basic rule.* Medicare Part B pays for outpatient physical therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician. . . .

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished –

(i) By a provider, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the direct supervision of a physical therapist in independent practice who is licensed by the State in which he or she practices. . . .

. . .

(c) *Special provisions for services furnished by physical therapists in independent practice* –

(1) Who is a physical therapist in independent practice. A physical therapist in independent practice is one who –

(i) engages in the practice of physical therapy on a regular basis;

(ii) furnishes services on his or her own responsibility without the administrative and professional control of an employer;

. . .

(2) *Limitation on Incurred Expenses*

. . .

(iii) From 1990 through 1993, not more than $750 of reasonable charges incurred in a calendar year are recognized as incurred expenses.

(iv) After 1993, not more than $900 of reasonable charges incurred in a calendar year are recognized as incurred expenses.

4. 42 C.F.R. Section 424.55(a) [1996]

(a) Medicare pays the supplier for covered services if the beneficiary . . . assigns the claim to the supplier and the supplier accepts assignment.

5. 42 C.F.R. Section 424.80 [1996]

(a) *Basic Prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement.

(b) *Exceptions to The Basic rule – (1) Payment to Employer.* Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services.

6. Medicare Carriers Manual Section 15002

Use the [Medicare] fee schedule when paying for the following physicians' services, if those services were payable on a reasonable charge or fee schedule basis prior to January 1, 1992.

. . .

Physical and occupational therapy furnished by physical therapists and occupational therapists in independent practices.

7. Medicare Carriers Manual Section 3060.E

Effect of Payment to Ineligible Recipients. – An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment. Sanctions may be invoked under § 3060.13 against a physician or other supplier to prevent

him from executing or continuing in effect such an authorization in the future, but neither the physician or other supplier nor the ineligible recipient is required to repay the Medicare payment. . . .

8. 42 U.S.C. Section 1395l(g) [As Amended In 1997 By Section 4541(c) Of The Balanced Budget Act of 1997]

Subject to paragraph (4), in the case of physical therapy services of the type described in § 1861(p) [42 U.S.C. § 1395x(p)]. . . . and physical therapy services of such type which are furnished by a physician or as incident to a physician's services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for the purposes of subsections (a) and (b).

. . .

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001 and 2002.

9. 42 C.F.R. Section 410.60 [As Amended November 2, 1998]

(a) *Basic Rule.* Medicare Part B pays for outpatient physical therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a Doctor of Medicine, Osteopathy, or Podiatric Medicine.

(2) They are furnished under a written plan of treatment. . . .

(3) They are furnished – (i) by a provider. . . . ; or (ii) by or under the personal supervision of a physical therapist in private practice as described in paragraph (c) of this section.

. . .

(c) *Special Provisions for Services Furnished by Physical Therapists in Private Practice. (i) Basic Qualifications.* In order to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:

(i) Be legally authorized . . . to engage in the private practice of physical therapy by the state in which he or she practices, . . .

(ii) Engage in the private practice of physical therapy on a regular basis as an individual, in one of the following practice types:

. . .

(C) An unincorporated solo practice, a partnership, or group practice, or a professional corporation or other incorporated physical therapy practice.

. . . .

(SEAL) **U.S. Department of Justice**

United States Attorney
Northern District of California

10th Floor, Federal Building *(415) 436-6925*
450 Golden Gate Avenue, Box 36055
FAX:(415) 436-6748
San Francisco, California 94102
e-mail: sara.winslow2@usdoj.gov

June 6, 2003

Cathy A. Catterson
Clerk of Court
United States Court of Appeals
for the Ninth Circuit
P.O. Box 193939
95 Seventh Street
San Francisco, CA 94119-3939

Re: *United States v. Mackby, No. 02-16778*

Dear Ms. Catterson:

Pursuant to Circuit Rule 36-4, the United States respectfully requests publication of the Court's June 3, 2003 memorandum disposition in the above-captioned case. A copy of the memorandum is enclosed.

This Court's opinion in the first appeal of this case was published (261 F.3d 821), as was the district court's opinion on remand (221 F. Supp.2d 1106), which was the subject of the above-referenced appeal. This Court's opinion in the first appeal of this case was the first appellate opinion holding that the Excessive Fines Clause of the Eighth Amendment applies to False Claims Act judgments. Since publication of that opinion, the Excessive

Fines Clause has frequently been raised as an issue in False Claims Act matters. To date, however, there has been no published appellate opinion applying Excessive Fines Clause analysis to a False Claims Act case. Accordingly, litigants lack insight into how appellate courts apply the Clause in False Claims Act cases. Publication of the Court's opinion would provide valuable guidance to False Claims Act litigants and potential litigants as they decide whether to bring cases, and as they determine whether and how to resolve cases.

Accordingly, we respectfully request that the memorandum be published.

Sincerely,

KEVIN V. RYAN
United States Attorney

By: /s/ Sara Winslow
SARA WINSLOW
Assistant United States Attorney

Enclosure

cc:
Patric Hooper, Esq., Attorney for Appellant Peter Mackby

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
X (Medicare#)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rogers [redacted]

3. PATIENT'S BIRTH DATE: 11 28 23 — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: [redacted] STATE: [redacted]

8. PATIENT STATUS: Single Married X Other

CITY: STATE:

ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted])

Employed Full-Time Student Part-Time Student

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M F

b. AUTO ACCIDENT? YES NO X — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER INSURED'S INSURANCE PLAN OR PROGRAM NAME: P O Box 25097 Oklahoma City OK 73193

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Standard Life

10d. RESERVED FOR LOCAL USE: SP

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 062096

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Bost Frederic M D

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A89177

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO — $ CHARGES: NO PURCH SVC

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 80 6
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: 0 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 13 96	06 13 96	11		97014		1	20 00	1				000G11460
2 06 13 96	06 13 96	11		97530		1	30 00	1				000G11460
3 06 13 96	06 13 96	11		97110		1	40 00	1				000G11460
4 06 17 96	06 17 96	11		97014		1	20 00	1				000G11460
5 06 17 96	06 17 96	11		97530		1	30 00	1				000G11460
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: J160147 X

26. PATIENT'S ACCOUNT NO.: 3425 MCR2

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 140 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 140 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Pickell Steve RPT

SIGNED: 062096 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Asher Clinic 000G1460
2801 Larkspur Landing Cr
Larkspur CA 94939

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

2801 Larkspur Landing Cr
Larkspur CA 94939
4154618233

PIN# GRP# 000G11460

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD — FIRST FOLD — WHITE IS ENVY WILE

BEST AVAILABLE COPY

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a), if item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted.

CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty

member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims. I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the *Federal Register*, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. "Republican of Notice of Systems of Records." *Federal Register* Vol. 55 No. 40. Wed Feb. 28 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: *PRINCIPLE PURPOSE(S)*: To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of

Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims: and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS
(PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including

suggestions for reducing the burden. • HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207 and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008). Washington, D.C. 20503.

(LOGO)

June 28, 1991

Medicare Provider Certification
P.O. Box 797
Turlock, CA 95381-0797

RE: Substitution of existing Provider Name and Number

Asher Clinic is requesting that Medicare please make the following changes accordingly:

Current	Change
Provider #000G11460 Provider Name: M. Judson Mackby,M.D. Practice Address: 1601 Larkspur Landing Larkspur, CA 94939 Telephone # (415) 461-8233 Fed Tax ID#68-0160147	#ZZZ25844Z Henning M. Bauer, R.P.T. License #PT012420 1601 Larkspur Landing Cr. Larkspur, CA 94939 # (415) 461-8233 #68-0160147

Please foward a letter of confimation to our office once the above information has been changed. If additional information is needed, or a new application needs to be completed, please forward the necessary infomation to: Asher Clinic 1601 Larkspur Landing Cr. Larkspur, CA 94939

Thank you for your prompt attention to this matter.

Sincerely,

/s/ Maridy Mikelson
Maridy Mikelson
Office Manager

(LOGO)
BLUE SHIELD

TURLOCK SERVICE CENTER
P.O. BOX 797, TURLOCK, CA 95381

July 11, 1991

Asher Clinic
1601 Larkspur Landing
Larkspur CA 94939

Provider No: ZZZ25844Z
CCN: 099118655320

Dear Provider:

We have received your request for a substitution of existing provider name and number. We are unable to comply with your request. Provider Identification Numbers are assigned for one individual only and are not reassigned.

We currently have Henning M. bauer listed as an active member of your group. Medical Doctors cannot be added to Physical Therapy groups.

If you have any questions, please contact our Customer Service Department at the above address or call (209) 634-9121.

/s/ Debra S. De Salles
Debra S. De Salles
Provider Certification
Department

Enclosure